DEPARTMENT OF HEALTH AND HUMAN SERVICES
FY 1998 BUDGET

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CREATING A STRONGER AND HEALTHIER NATION

As we move toward a new century, our Nation faces significant health and human service challenges. Advances in biomedical research and medical technologies, changing demographics, and transformations in the structure and delivery of health care, public health, and social services all present us with new opportunities and new demands. The President's FY 1998 budget for the Department of Health and Human Services (HHS) ensures that our Nation's health and social services programs will have the flexibility to address these changes.

Our budget takes several critical steps toward creating a stronger and healthier nation:

- It puts us on a path to balancing the budget by 2002;
- It preserves Medicare and Medicaid by reforming, strengthening, and modernizing both programs;
- It assists growing numbers of American families who lack health insurance coverage;
- It provides assistance and support to States as they assume new responsibilities under welfare reform and to families as they make the transition to work;
- It helps families raise strong and healthy children by strengthening our investment in Head Start, teen pregnancy prevention and abstinence education; increasing opportunities for adoption; and bolstering our efforts to reduce tobacco use and drug abuse among youth; and
- It strengthens the health and safety of our Nation by sustaining biomedical research at the National Institutes of Health, developing a new food safety initiative, combating infectious diseases, and providing life-extending drug therapies to people with AIDS.

The President's plan for the FY 1998 budget proposes a balanced budget by FY 2002 through a combination of program savings, responsible reforms and strong management. The Department of Health and Human Services plays a major role in this balanced budget effort.

The President's FY 1998 budget for the Department of Health and Human Services totals $376 billion in outlays, an increase of $25 billion, or 7 percent, over the comparable FY 1997 amount. The discretionary portion of the HHS budget totals $34.7 billion in budget authority, an increase of 1.4 percent over the FY 1997 level.

PRESERVING AND STRENGTHENING MEDICARE AND MEDICAID

Medicare

The President's Medicare plan preserves and modernizes the program, reducing projected spending by a net $100 billion over five years while guaranteeing the solvency of the Part A Hospital Insurance trust fund until 2007. We are reforming Medicare to make it more efficient and responsive to beneficiary needs, give seniors more choices among private health plans, cut the growth of provider payments, and hold the Part B premium to 25 percent of program costs.

In FY 1998, HHS will continue to crack down on Medicare and Medicaid fraud and abuse through implementation of the Medicare integrity and anti-fraud and abuse programs that are authorized by the Health Insurance Portability and Accountability Act of 1996. Building on the successes of the HHS pilot

project, *Operation Restore Trust*, HHS and the other Federal, State, and local partners will expand anti-fraud efforts to all 50 states. CBO estimates $3 billion in health care costs will be saved over seven years through these efforts.

Medicaid

The President's plan for Medicaid reforms the program but preserves the guarantee of health and long-term care coverage for the most vulnerable Americans. Over 37.5 million children, pregnant women, people with disabilities, and the elderly would continue to receive basic health and long-term care services under Medicaid. Recognizing that growth in Medicaid spending has declined significantly over the past two years, this budget seeks to maintain those lower spending levels in the outyears when spending growth is projected to rise again. The President's legislative proposals for Medicaid will achieve a net savings of $9 billion over the five years, from 1998 through 2002. This total is comprised of both spending and savings proposals that improve and strengthen the Medicaid program, while more appropriately targeting spending for our most vulnerable populations. The President's Medicaid savings are achieved through the establishment of a per capita cap and through the retargeting of Disproportionate Share Hospital spending, for a total of $22 billion over five years. The major spending initiatives also include our children's health initiative and our welfare reform related proposals.

The plan also helps States meet the most pressing needs, while giving States unprecedented flexibility to administer their programs more efficiently. Finally, the plan retains current nursing home quality standards and continues to protect the spouses of nursing home residents from impoverishment.

MAINTAINING AND EXPANDING HEALTH CARE COVERAGE FOR WORKING FAMILIES

The FY 1998 budget builds upon last year's health insurance victory for working Americans--the Health Insurance Portability and Accountability Act of 1996. This Act guarantees access to health insurance for small firms, regardless of the health status of any group of members; limits the use of exclusions due to pre-existing conditions; and guarantees access to health insurance for people moving into the individual market from a group plan.

As a part of the President's health legislation package, our budget includes $25 million each year for five years in grants to States to establish voluntary health insurance purchasing cooperatives to take advantage of economies of scale to which small firms normally do not have access in purchasing health insurance.

The budget also includes $1.7 billion to help States finance up to six months of health insurance coverage for temporarily unemployed workers and their families. The program will be available to recipients with incomes below a certain level, who had employer-based coverage in their prior jobs. States will have substantial flexibility to administer the demonstration program. This program will help more than 3 million working Americans and their families, including 700,000 children.

An estimated 10 million children in America today do not have health insurance. The President is proposing a series of steps to help address this problem and reach the goal of reducing the number of uninsured children by half by the end of FY 2000. First, the budget proposes $750 million in annual grants to States to build on their recent successes in working with insurers, providers, employers, schools, and others to develop innovative ways to provide health insurance coverage to children. Second, the budget provides funds to allow States the

option to extend one year of continuous Medicaid coverage to children, thus increasing continuity and security for children and families. The proposal would reduce administrative burdens on States, families, and health care plans that now have to determine eligibility on a monthly basis. Finally, we will work with the Nation's Governors to develop new ways to reach out to the 3 million children who are currently eligible for Medicaid but are not presently enrolled. In addition, under current law an estimated 250,000 14-year-olds will become eligible for Medicaid in 1998.

BUILDING STRONG FOUNDATIONS FOR FAMILIES AND CHILDREN

The best gifts we can give our children are strong families, safe communities, and good health. Strong foundations are important for every child's future. Both research and the experiences of parents and caregivers tell us that a child's environment during the early years is especially critical to their ability to succeed in school and later in life.

In addition to expanding health care coverage for children, this budget includes many other special initiatives to help our children and families.

Tobacco: Every year, more than 400,000 people die from tobacco-related cancer, respiratory illness, heart disease, and other health problems. At the same time, each year another million young people become regular smokers. The vast majority of adults who smoke began doing so before their 18th birthday. Consequently, in August 1996, the Administration approved an FDA regulation of tobacco products that aims to cut tobacco use among young people by half over seven years by reducing access and appeal.

Our budget includes $34 million to implement the regulation. The budget also provides $36 million for the Centers for Disease Control and Prevention (CDC) and $22 million for the National Institutes of Health (NIH) for financial and technical support to States for tobacco prevention and control activities. In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) is working with States to support enforcement of State laws that prohibit the sale of tobacco products to minors.

Reducing Substance Abuse Among Youth:

After years of steady decline, marijuana use is rapidly increasing among American youth. As much a cause for concern is the fact that adolescents increasingly feel there is little or no risk to themselves or others in their abusing drugs. To reverse these trends, the Department is increasing the resources dedicated to its new youth substance abuse prevention initiative.

The FY 1998 budget increases support for SAMHSA to $98 million to mobilize and leverage Federal and State resources, raise awareness and counter pro-use messages, and measure outcomes. Approximately $63 million will be dedicated to State Incentive Grants. These grants call upon Governors to develop comprehensive State-wide strategies to reduce youth substance abuse. In designing their plans, States may propose their own approaches but will be offered a menu of effective substance abuse prevention strategies and programs that are based on scientific research. SAMHSA will focus public education efforts on reaching youth and their caregivers by integrating and expanding its Girl Power! and Reality Check-anti-drug use campaigns. And to measure outcomes, approximately $28 million will be used to expand SAMHSA's National Household Survey on Drug Abuse. The Household Survey now provides data for making national estimates on the prevalence of substance abuse in the population age 12 years and older as well as

information on behavior, attitudes, and household environment. The expansion will also provide State-by-State data on these same measures, allowing Governors and others to know where efforts are succeeding and where improvement is needed. The Administration also calls on Congress to enact SAMHSA's Performance Partnership Block Grant proposal, which would give States more flexibility to better design and coordinate their anti-abuse programs and target resources to community priorities.

Our request also includes an increase of $30 million for the NIH which is part of the Administration's cross-cutting commitment to combat drug abuse. The $30 million will be targeted to the high priority areas of understanding the role of brain functioning in the development and consequences of addiction; drug abuse among children and adolescents; the role of drug abuse as the primary vehicle for the transmission of HIV; behavioral research, and prevention research. The increased funding will further the development of a medication for the treatment of cocaine addiction.

Head Start: Studies of children enrolled in Head Start programs continue to show that the Head Start experience has a positive impact on school readiness, increases children's cognitive skills, boosts self-esteem and achievement motivation, and improves school social behavior. Head Start has also been shown to help parents improve their parenting skills, increase participation in their children's school activities and, in many cases, help parents on the road to self-sufficiency. In short, Head Start works and needs to be expanded to reach more Head Start-eligible children in families not currently served by the program. The budget includes $4.3 billion, $324 million more than in 1997, to ensure that Head Start stays on track to serve 1 million children by 2002. The additional funds will allow Head Start to serve an additional 36,000 new children and their families, bringing total Head Start enrollment to an estimated 836,000.

Adoption Initiative: Each year, State child welfare agencies secure homes for less than one-third of the children for whom the goal is adoption or other permanent placement. These children wait an average of three years to be placed in permanent homes. President Clinton has challenged States and Federal agencies to at least double, by the year 2002, the number of children in foster care who are adopted or permanently placed each year. HHS will lead the effort to raise public awareness, identify barriers to permanent placement, set numerical targets with States, and reward successful performance. To accomplish this, the FY 1998 budget includes $21 million for an adoption initiative. Funds will be used to provide training and enhanced technical assistance to States; support grants to States to assist them in removing barriers to adoption or permanent placement; engage business, church and community leaders in this initiative; and develop and lead a public awareness effort to include public service announcements, print material and increased use of Internet resources to promote adoption. In addition, our budget proposes paying incentives to States for increases in adoptions which will be offset by anticipated reductions in foster care costs.

Preventing Teen Pregnancy: Teen pregnancy rates are declining, but more needs to be done to address this national problem. Each year, about 200,000 teens ages 17 and younger have children. Their babies are often low birth weight and are at high risk for infant mortality. They are also far more likely to be poor. In fact, about 80 percent of the children born to unmarried teenagers who have dropped out of

high school are poor. In contrast, just 8 percent of children born to married high school graduates aged 20 or older are poor. The FY 1998 budget includes $14.2 million for the Adolescent Family Life Program, an abstinence based education program, that builds on the Administration's ongoing efforts to help communities prevent out-of-wedlock teen pregnancies. In addition, the new welfare reform law signed by President Clinton on August 22, 1996, provides $50 million a year in new Health Resources and Services Administration (HRSA) funding for State abstinence education activities, beginning in FY 1998.

PUBLIC HEALTH AND SAFETY FOR THE 21ST CENTURY

Investments in public health can yield substantial returns -- fewer premature deaths, fewer and less costly illnesses, and healthier, more productive lives. The FY 1998 budget invests in biomedical research and in public health initiatives that show great promise for ameliorating critical health problems while controlling future costs.

Biomedical Research: The budget continues the Administration's longstanding commitment to biomedical research, which advances the health and well-being of all Americans. For the NIH, it proposes $13.1 billion for biomedical research that would lay the foundation for future innovations that improve health and prevent disease. The budget includes $223 million to emphasize research in six areas NIH has identified as showing the most promise for addressing public health needs and yielding medical advances, including research on the biology of brain disorders; new approaches to pathogenesis; new preventive strategies against disease; genetics of medicine; advanced instrumentation and computers in medicine and research; and new avenues for therapeutics development. In addition, the request funds research on HIV/AIDS, breast cancer, drug abuse, spinal cord injury and regeneration as well as many other diseases and disorders that affect the health, productivity, and quality of life of all Americans. The budget request also includes the second year of funding for a new Clinical Research Center, which will give NIH a state-of-the-art research facility in which researchers can continue to bring the latest medical research discoveries directly to patients' bedsides.

In just the past year, NIH-sponsored research has produced many major advances, such as locating the first major gene that predisposes men to prostate cancer; pinpointing the location of the gene that researchers believe is responsible for familial Parkinson's disease; and unveiling a map which identifies the locations of over 16,000 genes in human DNA, about one-fifth of the estimated 80,000 genes packaged within the human chromosomes. This will give researchers a ready list of "candidates" for genes involved in human diseases.

Food Safety: In recent years, new and serious food safety problems have occurred with increasing frequency, including illness outbreaks caused by foodborne pathogens such as *E. coli, Salmonella enteritidis, Vibrio vulnificus, and Cyclospora*. The CDC has recently estimated that there are as many as 33 million cases of foodborne illnesses each year in the United States. These illnesses are estimated to result in up to 9,000 deaths annually. To respond effectively to these food safety issues, the President has proposed a $43 million food safety initiative, including $34 million in FY 1998 for CDC and FDA, to strengthen surveillance systems for food-borne illnesses nation-wide, and to improve Federal-State coordination when food-borne disease outbreaks occur.

The budget would also further support a modernized system of food safety inspection in the seafood industry that quickly identifies potential food safety hazards in the production and processing of such food. In addition, the U.S. Department of Agriculture is a partner in this initiative, with an increase of $9 million requested in FY 1998.

Infectious Disease: Recent outbreaks of a variety of infectious diseases have shown the public that emerging and re-emerging infectious diseases are an important potential threat to public health. Anticipating and preventing infectious diseases are far less costly, in human suffering and economic terms, than reacting with expensive treatment and containment measures once public health emergencies occur. To address this need, the budget includes $59 million, $15 million more than in 1997, for CDC's efforts to address and prevent emerging infectious disease. Funds will strengthen significantly the States' disease surveillance capability, applied research, and training.

HIV Treatment and Prevention: In 1996, the Ryan White Care Act was reauthorized with strong bipartisan support. The budget proposes over $1 billion for HRSA's Ryan White activities, $40 million more than in 1997. This will help our most hard-hit cities, States, and local clinics provide medical and support services to individuals with HIV/AIDS. Under this Administration, funding for Ryan White grants has risen by 158 percent. The 1998 budget would fund grants to cities and States to help finance medical and support services for individuals infected with HIV; to community-based clinics to provide HIV early intervention services; to pediatric AIDS and HIV dental activities; and to HIV education and training programs for health care providers.

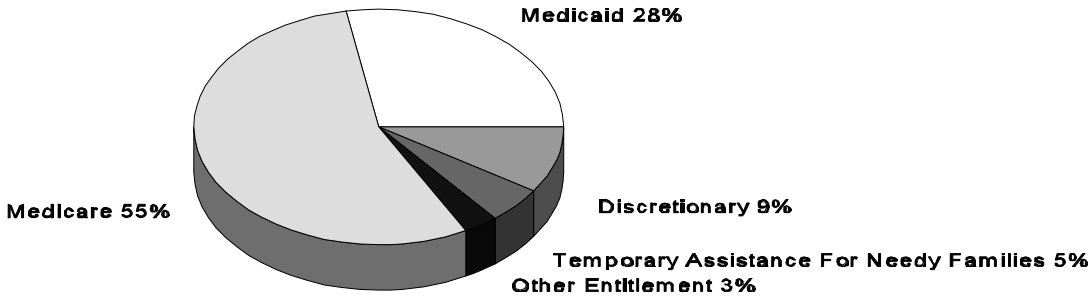
The FY 1998 Ryan White request includes $167 million specifically for the AIDS drug assistance programs, while providing cities and States the flexibility to use other Ryan White dollars for drug assistance. The budget proposes $634 million for the CDC's HIV prevention activities, $20 million more than in 1997, to help prevent HIV among injecting drug users, who are at great risk of HIV infection. Finally, the budget proposes $1.5 billion to continue research efforts in HIV infection and AIDS supported by NIH.

Summary
Department of Health and Human Services

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Budget Authority/Income	$318,489	$358,207	$369,344	$11,137
Outlays	$319,855	$351,082	$375,825	$24,743

PRESIDENT'S BUDGET FOR HHS
FY 1998



$376 BILLION IN OUTLAYS

HHS Budget by Operating Division

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Food and Drug Administration				
Program Level	$980	$996	$1,064	$68
BA	877	888	820	-68
Outlays	865	918	852	-66
Health Resources and Services Administration				
BA	3,241	3,609	3,402	-207
Outlays	3,953	3,434	3,483	49
Indian Health Services				
BA	1,984	2,054	2,122	68
Outlays	2,027	2,117	2,091	-26
Centers for Disease Control and Prevention				
BA	2,144	2,302	2,316	14
Outlays	2,198	2,189	2,271	82
National Institutes of Health				
BA	11,928	12,741	13,078	337
Outlays	10,212	12,146	12,786	640
Substance Abuse and Mental Health Services Administration				
BA	1,885	2,171	2,206	35
Outlays	2,084	1,892	2,089	197
Agency for Health Care Policy and Research				
BA	65	96	87	-9
Outlays	81	95	88	-7

HHS Budget by Operating Division, continued

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Health Care Financing Administration				
BA	261,777	295,203	310,371	15,168
Outlays	266,152	292,718	315,318	12,600
Administration for Children and Families				
BA	33,305	*38,630	34,624	-4,006
Outlays	31,023	35,024	36,521	1,497
Administration on Aging				
BA	833	836	838	2
Outlays	820	855	835	-20
Departmental Management				
BA	188	218	195	-23
Outlays	158	232	202	-30
Office of Inspector General				
BA	81	105	112	7
Outlays	72	109	113	4
Program Support Center				
BA	212	224	236	12
Outlays	241	223	239	16
Receipts				
BA	-31	-31	-31	0
Outlays	-31	-31	-31	0
Child Support Receipts Account (ACF)				
BA	0	-839	-1,032	-193
Outlays	0	-839	-1,032	-193
TOTAL, HHS				
BA	$318,489	$358,207	$369,344	$11,137
Outlays	$319,855	$351,082	$375,825	$24,743
Full-time Equivalents	57,360	57,360	57,360	0

* Includes $937 million of CCDBG funding available October 1, 1998.

Composition of the HHS Budget

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/-Enacted
Entitlement Programs (Outlays):				
Medicare	$172,434	$192,442	$207,742	$15,300
Medicaid	91,990	98,542	105,801	7,259
Family Support Payment to States/TANF	16,670	18,814	19,706	892
Foster Care and Adoption Assist	3,691	3,789	4,071	282
Social Services Block Grant	2,484	2,694	2,621	-73
JOB Opportunities and Basic Skills	931	324	89	-235
State Legalization Impact Assist. Grts	-2	2	0	-2
Family Support Preservation	126	186	227	41
Other/Financing Offsets	381	1,264	1,425	161
Subtotal, Entitlement Programs:				
Outlays	288,705	318,057	341,682	23,625
Discretionary Programs (Budget Authority):				
National Institutes of Health	11,928	12,741	13,078	337
Other Public Health Programs	10,052	10,895	10,869	-26
HCFA Program Management	1,728	1,734	1,775	41
Children & Family Services Programs	4,766	5,364	5,499	135
Low Income Home Energy Assistance	1,080	1,005	1,000	-5
Grants to States for Child Care	935	956	1,000	44
Administration on Aging	833	836	838	2
Refugee & Entrant Resettlement	413	427	396	-31
Departmental Management	168	198	174	-24
Office for Civil Rights	20	20	21	1
Office of Inspector General	37	35	32	-3
Subtotal, Discretionary Programs:				
Budget Authority	31,960	34,211	34,682	471
Outlays	31,150	33,025	34,143	1,118
TOTAL, HHS OUTLAYS	$319,855	$351,082	$375,825	$24,743

Food and Drug Administration

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Program Level	$980	$996	$1,064	+$68
Budget Authority	877	888	820	-68
Outlays	865	918	852	-66
FTE	9,172	9,180	9,180	0

Summary

The FY 1998 budget request for the Food and Drug Administration (FDA) is $1,064 million in program level, a 7 percent increase over FY 1997, of which $244 million is derived from targeted industry-specific user fees. In addition, FDA is proposing two new important public health initiatives--food safety and youth tobacco prevention.

The FDA is the principal consumer protection agency of the Federal government. FDA's goal is to protect the public health through the prevention of injury or illness due to unsafe or ineffective products. FDA's authority is to ensure that food is safe and wholesome; drugs, biological products, and medical devices are safe and effective, cosmetics are unadulterated; radiological products do not cause unnecessary exposure to radiation; and that all of these products are honestly and informatively labeled.

Food Safety

Late in 1996, an outbreak of E. coli-contaminated unpasteurized apple juice sickened dozens in several States and killed one child. To prevent future incidents such as this one caused by foodborne pathogens like E. coli and salmonella, FDA--in tandem with the Centers for Disease Control and Prevention, the U.S. Department of Agriculture and the Environmental Protection Agency--is launching an important food safety initiative. The FY 1998 FDA request includes an additional $24 million for six strategic components:

- Inspections--increase inspections to implement the Hazard Analysis Critical Control Point (HACCP) for seafood;
- Surveillance--create the ability to rapidly detect foodborne illness outbreaks;
- Coordination--increase coordination at all

levels of government;

- Education--provide food safety education programs and materials;

- Risk assessment--improve health risk estimates to facilitate the development and evaluation of surveillance and risk reduction plans; and

- Bioscience Research--develop new improved tools and methods to identify and evaluate foodborne hazards.

Youth Tobacco Prevention

Every year, another 1 million young people become regular smokers, and one-third of them will eventually die prematurely as a result of their smoking. In August 1996, President Clinton announced to the American public FDA's final rule designed to decrease young people's use of tobacco by 50 percent over seven years through the regulation of nicotine-containing tobacco products. FDA's budget includes $34 million to implement this important regulation. This will be done through outreach with retailers, state and local officials, communities, and the media. Developing a strong outreach program is one of the most effective ways to increase compliance with the new rule.

FDA will also emphasize efforts by commissioning State and local offices who will enforce the final rule by conducting compliance checks to make sure that retailers do not sell tobacco to minors. FDA will establish the necessary training experiences for those State and local officials conducting the compliance checks.

User Fees

The FY 1998 budget builds upon the successful implementation of the Prescription Drug User Fee Act (PDUFA) and the Mammography Quality Standards Act (MQSA) which authorized the collection of user fees for reviewing drug applications and inspecting mammography facilities, respectively. The FY 1998 budget proposes reauthorization of these two programs -- PDUFA ($91 million) and MQSA ($14 million). Under PDUFA in FY 1996, FDA approved 121 new drug applications (NDAs) with a median approval time of 15 months--70 percent more than in FY 1995. This was achieved while decreasing the median approval time by 20 percent. Of these NDAs, 42 were approved in 12 months or less--110 percent increase over FY 1995.

Consistent with recommendations of the Vice President's 1993 National Performance Review, the budget also includes $131 million in user fees that will be dedicated to finance other areas of FDA regulation such as medical devices, animal drug approvals, import inspections, generic and over-the-counter drug applications, and establishment fees. In addition FDA will continue the collection of fees for export certification and insulin and color additive certifications.

Arkansas Regional Laboratory

FDA is requesting $14.6 million in FY 1998 to complete construction of the Arkansas Regional Laboratory in Jefferson, Arkansas. The Arkansas Regional Laboratory is a cornerstone of FDA's consolidation plan that will provide State-of -the-art and laboratory programs.

FDA OVERVIEW

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Salaries and Expenses				
Foods	$201	$200	$220	+20
Drugs	407	413	424	+11
Medical Devices	157	160	166	+6
National Center for Toxicological Research	31	31	31	0
Tobacco	5	5	34	+29
Other Activities	94	90	90	0
Other Rent &Rent Related Activities	22	23	23	0
Subtotal, Salaries & Expenses	$917	922	988	+66
GSA Rental Payments	46	46	46	0
Buildings & Facilities	12	21	23	+2
Certification Fund	5	5	5	0
Export Certification	0	2	2	0
Total, Program Level	$980	$996	$1,064	+$68
Less User Fees:				
Current Law:				
Revolving Fund	5	5	5	0
Export Certification	0	2	2	0
Proposed Law:				
Prescription Drugs	85	88	91	+3
Mammography Inspections	13	13	14	+1
Food & Cosmetics	0	0	47	+47
Drugs	0	0	25	+25
Animal Drugs & Feeds	0	0	13	+13
Medical Devices	0	0	45	+45
Biologics	0	0	2	+2
Subtotal, User Fees	$103	$108	$244	+$136
Total, Budget Authority	$877	$888	$820	-$68
FTE	9,172	9,180	9,180	0

Health Resources and Services Administration

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Budget Authority	$3,075	$3,401	$3,269	-132
Program Level	$3,081	3,407	3,280	-127
Outlays	3,826	3,251	3,320	+69
FTE	1,861	1,890	1,890	0

Summary

The FY 1998 budget request for the Health Resources and Services Administration (HRSA) is $3.3 billion, a net reduction of $132 million from 1997. HRSA grants improve the health of the Nation by providing access to quality health care to underserved, vulnerable, and special-need populations, and by encouraging participation of minority and disadvantaged students in the health programs.

Over the past several years the introduction of managed care has changed the way services are delivered, paid for, and managed. These changes and others impact on how the populations aided by HRSA programs are actually served. To address these changes, HRSA has begun to reinvent itself. This reinvention will enhance the effectiveness of program operations; foster linkages and integration with broader State and community-based health care systems; create an organization and a decision-making process responsive to customer needs; and continue fostering diversity.

HIV/AIDS

In 1996, the Ryan White Care Act was reauthorized with strong bipartisan support. This legislation, a top priority of the Clinton Administration, has provided care to more than 500,000 Americans living with HIV or AIDS. The FY 1998 request of just over $1 billion for Ryan White treatment activities is an increase of $40 million, or 4 percent over the FY 1997 level. This request includes $455 million for emergency relief grants to 49 cities and communities. A total of $432 million is requested for formula grants to States, an increase of $15 million. Of this amount, $167 million is for the Drug Assistance Program (ADAP). In an effort to give States the flexibility to provide a combination of primary care AIDS services--AIDS drugs, insurance continuation and other medical and support services-- to best meet their own needs, the budget provides the increase to the overall State grant program. Protease inhibitors--taken in combination with other AIDS drugs--have revolutionized AIDS treatments. Researchers have found that these drugs, when taken in combination with other AIDS medications, can reduce the virus to undetectable levels for some people living with HIV/AIDS. For the first time in the history of the epidemic, there is strong evidence that

pharmaceuticals, when delivered in the context of primary care, can actually extend lives of people living with HIV/AIDS.

A total of $85 million is requested in discretionary grants to allow an additional 3,000 individuals who are infected with, or at-risk of, HIV infection to receive primary care services. A total of $40 million is requested for grants for coordinated HIV services and access to research for children, youth, women, and families. In addition, $17 million is included for AIDS Education and Training Centers and $7.5 million for the AIDS Dental Reimbursement program.

Consolidated Health Centers

Community and Migrant Health Centers, Health Centers for the Homeless, and Health Centers near Public Housing form a major component of our Nation's health safety net. Through a Federal, State, and community partnership approach, 8.4 million individuals in 2,250 underserved communities receive high quality, cost-effective, accessible, and affordable preventive and primary health care services. The direct Federal grant funds, currently about 30 percent of total revenues, leverage resources from patient fees, Medicaid, Medicare, and other third party sources.

The FY 1998 budget request for Consolidated Health Centers includes $810 million, an $8 million increase, to be focused on services to uninsured and underinsured children through the Healthy Schools, Healthy Communities initiative. Complementary to the Consolidated Health centers program, the National Health Service Corps is funded at $115 million. The National Health Service Corps is often the only source of providers of care for the underserved; especially in communities with high rates of infant mortality, poverty, and substance abuse. In many rural areas, they are the sole providers.

Health Professions

Through a wide array of discretionary grant programs, the Federal government--over the past 30 years--has targeted resources on solving problems in the distribution and procurement of health care personnel which were not addressed well by market demand. HRSA has spent over $10 billion to increase the supply of health professionals and to assure the appropriate mix of specialists and generalists. Over these 30 years, the nation has had substantial increases in the supply of primary care physicians, and most of the allied health professions. The Federal government, as a part of the President's Plan to achieve a balanced budget, will decrease investments in many of the discretionary training grants that have been a traditional component of the health professions program.

The budget for FY 1998 focuses on continued achievements in increasing minority and disadvantaged representation in the health professions and in the Area Health Education Centers which address workforce supply and distribution. Other health profeesions programs--primary care medicine and public health activities and programs to strengthen basic and advanced nurse education and practice--are funded at lower levels.

Services to Mothers and Children

HRSA has a strong commitment to investing in the health of women and children. Funding for these efforts total over $1 billion, and is about level with the spending in FY 1997. These programs include the Maternal and Child Health Block grant, a Federal/State partnership focusing on meeting the health needs of mothers and children in the context of families and communities ($681 million); Healthy Start, an initiative designed to reduce infant mortality rates ($96 million); the Emergency Medical Services for Children program ($12 million); and the Title X Family Planning program ($203 million, an increase of $5 million).

The increase in the Family Planning program will provide services to an additional 40,000 women, as well as address emerging trends that impact on providing effective and efficient family planning services--male involvement in family planning and reproductive health and update computer capabilities. The budget also includes a $50 million mandatory appropriation for a new abstinence education supplement to the Maternal and Child Health Block Grant.

Organ Transplantation

Today, the demand for organs for transplantation is growing at a faster rate than actual donations, resulting in a growing disparity between the demand and the availability of organs for transplantation. To help close this gap, The FY 1998 budget requests $4 million nearly doubles the resources previously available for organ transplantation activities. A high priority for this program will be investment in making the public more aware of the need through developing and implementing targeted public education programs, developing and disseminating curriculum for children in grades K through 12, and conducting regional college awareness workshops.

Other HRS Programs

For the remaining HRSA programs, total spending of $166 million is proposed. This level will ensure sufficient funds are available to adequately fund rural health initiatives, internal HRSA management initiatives critical to the agency's restructuring and national leadership responsibilities, treatment of Hansen's Disease, and the National Bone Marrow Donor Registry. Several smaller programs--the Nursing Loan Repayment and the Community-Based Scholarship programs--which duplicate activities of the National Health Service Corps-- will be discontinued.

HRSA OVERVIEW
DISCRETIONARY SPENDING

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
HIV/AIDS Activities (Ryan White)	$757	$996	$1,036	+$40
Consolidated Health Centers	758	802	810	+8
National Health Service Corps	112	115	115	0
Health Professions Clusters:				
Workforce Development	0	1	1	0
Enhanced Area Health Education	46	55	24	-31
Minority/Disadvantaged	80	89	89	0
Primary Care Medicine & Public Health	75	82	8	-74
Nursing Education	56	63	8	-55
Subtotal, Health Professions	257	290	130	-160
Maternal and Child Health Block Grant	678	681	681	0
Abstinence Education (non-add)*	0	0	(50)	(+50)
Healthy Start	93	96	96	0
Family Planning	193	198	203	+5
Rural Health Research	9	9	9	0
Rural Health Outreach	28	28	25	-3
Organ Transplantation	2	2	4	+2
Malpractice Databank	6	6	8	+2
Office of Drug Pricing	0	0	3	+3
Health Care Facilities	20	13	0	-13
Hansen's Disease Cluster	20	20	16	-4
Program Management	112	113	111	-2
HEAL Direct Operations	3	3	3	0
Other Services	33	35	30	-5
Subtotal, Disc. Program Level	$3,081	$3,407	$3,280	-$128
Less Offsets	6	6	11	+5
Total, BA	$3,075	$3,401	$3,269	-$132
FTE	1,861	1,890	1,890	0

* Abstinence Education is a new mandatory program.

Indian Health Service

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Budget Authority	$1,984	$2,054	$2,122	$68
Program Level	2,241	2,342	2,412	+70
Outlays	2,027	2,117	2,091	-26
FTE	14,401	14,415	14,415	0

Summary

The FY 1998 budget request for the Indian Health Service (IHS) is $2.4 billion, a $70 million increase in program level above FY 1997. The additional funds will primarily be used to begin replacement of two aging and overcrowded health care facilities in Arizona (Fort Defiance and the Keams Canyon).

The budget also requests funds for staffing of newly built health care facilities, additional tribal contracting, purchase of medical care from the private sector, and to provide a focus on subsets of the Indian population with special needs, e.g., women, children, and elders. The budget assumes collection of $285 million in insurance payments (e.g., Medicare, Medicaid, employer provided) for Indian patients, consistent with FY 1997 levels, and $4.7 million from rental of staff quarters.

Agency Description

IHS provides medical care to an estimated 1.4 million American Indians and Alaska Natives who are members of Federally recognized tribes. Medical care is provided directly through a network of 49 hospitals, 190 health centers, and 294 smaller facilities located primarily in Oklahoma, the Northern Plains, along the Pacific Coast, Alaska, and the Southwest. Local tribes operate 11 of the hospitals, 129 of the health centers, and 243 of the smaller facilities, under contracts authorized by the Indian Self-Determination and Contracting Act. IHS also purchases health care from local hospitals and health care providers where it is not economical to provide it directly ($368 million in FY 1997). While care is primarily provided in areas on or near reservations, grants are also awarded to organizations providing health care in 41 urban areas with substantial numbers of Indian people ($25 million in FY 1997). In addition to medical care, preventive and public health services, including provision of water and sewer services to Indian homes, and behavioral health services (e.g., mental health, alcohol/substance abuse prevention and

treatment) are also provided. IHS also provides funds to increase the supply of Native American health care providers and of providers serving Indian people.

The health statistics for Indian people have improved dramatically since IHS began keeping records in the early 1970s, for example a 40 percent decline in the overall mortality rate for the population IHS serves. Improvements occurring over the last 5 years include a 5 percent decrease in the death rate from suicides and, for males, an 18 percent decrease in the death rate from motor vehicle accidents.

Improvements at the HHS Level

HHS has worked to ensure that its responsibility for Indian people is not confined to the IHS. In June of 1996, the Health Care Financing Administration (HCFA) approved a 50% increase in the rates paid to IHS facilities under Medicare and Medicaid, to ensure parity between rates paid to IHS and non-IHS facilities. It has been several years since the base for these rates has been re-calculated. IHS and HCFA are working to improve IHS' cost accounting which will better enable IHS to respond to changes in the health care marketplace such as the increased use of managed care. IHS predicts that the rate change, along with an expansion in the definition of IHS facilities, will increase its Medicare and Medicaid reimbursements by $66 million, a +41% increase compared to FY 1995 collections. Also in 1996, the Administration on Children and Families changed the formula by which Federal child care funds are divided between Tribes and States. This change will increase the amount of child care funding received directly by tribes from $28 million in FY 1996 to $58 million in FY 1997.

Changes From FY 1997

With the additional $68 million requested in budget authority, IHS will fund several new initiatives including:

- **Facility Construction ($39 million; +$24 million)** IHS will begin construction of two health facilities in Arizona, replacing a 59 year old facility at Fort Defiance on the Navajo reservation, and a 36 year old facility at Keams Canyon on the Hopi reservation. These facilities are designed to provide an additional 75,000 outpatient visits annually and will also offer new services including physical therapy, dialysis treatment, intensive care, and inpatient adolescent psychiatry. IHS is requesting a total of $109 million for these facilities, additional funds are requested as an advanced appropriation in FY 1999 and FY 2000.

- **Sanitation Construction ($90 million; +$2 million)** IHS will be able to provide water and waste disposal services to 9,040 existing Indian homes, up from 8,800 homes in FY 1997, and will also provide services for 4,800 new homes, the same as in FY 1997. Since IHS began providing water and waste disposal services to Indian homes, postneonatal mortality rates have declined by 40 percent and gastroenteric mortality rates by 80 percent.

- **Contract Support Costs ($173 million; +$12 million)** Additional Funds are requested for the overhead and start up costs of new or expanded self-determination contracts with tribes and tribal organizations (+$7.5 million was provided for this purpose in FY 1997). IHS predict tribes and tribal organizations will contract for additional programs in FY 1998 bringing their total

funding to $796 million , a $40 million increase compared to FY 1997.

- **Operation of New Facilities (+$10 million)** The request includes funds for an additional 116 FTE staff for four facilities opening in FY 1996, FY 1997, and FY 1998. These facilities are: Anchorage, AK; Kotzebue, AK; White Earth, MN; and Harlem, MT.

- **Contract Health Services ($374 million; +$6 million)** These funds are used to purchase medical care from the private sector. Additional dollars will be used to respond to annual increases in the population served (+2 percent) and the cost of providing medical care (+5 percent as measured by the medical component of the CPI). Funds will also be available if there are any new Federally recognized tribes in FY 1998.

- **Populations With Special Needs (+$4 million)** IHS will use the additional funds to address the special health needs of particularly vulnerable sub-populations (e.g., women, elders, and children). The problems of these special populations are often connected with high rates of alcohol/substance abuse. Of the added funds, $3 million is for the special populations who will be served by tribal grants. An additional $1 million will also be provided to the urban health grantees.

- **Direct Operations ($47 million; - $2 million)** As part of its continuing efforts to shift resources from Headquarters to the local, or Service Unit, level, the program increases requested by IHS are offset by a decrease in funding for Direct Operations.

- **Increased Pay Costs (+$13 million)** Funds are requested to cover a portion of cost of legislatively mandated pay costs (2.7 percent in 1997 and 3.1 percent in 1998). A portion of these funds will be used for the salary costs of tribal contractors.

- **Adjustments (-$1 million)** IHS' request for purchase of medical equipment ($13 million) is the same as FY 1997 when the additional cost of equipping the new Anchorage Alaska Medical Center are excluded. The request also includes a transfer of $12 million, for the utility costs of health facilities, from the Services to the Facilities Appropriation.

IHS OVERVIEW

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Clinical Services *	$1,405	$1,452	$1,468	+$16
Contract Health, Non Add	(363)	(368)	(374)	(+6)
Preventive Health	78	81	82	+1
Urban Health	24	25	26	+1
Direct Operations	48	49	47	-2
Contract Support Costs	153	161	173	+12
Other Health Services	37	38	39	+1
Subtotal, Health Services	$1,745	$1,806	$1,835	+$29
Facility Construction	$12	$15	$39	+$24
Sanitation Construction	85	88	90	+2
Facility/Environmental Health Support *	90	91	105	+14
Other Facilities	52	54	53	-1
Subtotal, Health Facilities	$239	$248	$287	+$39
Total, Budget Authority	$1,984	$2,054	$2,122	+$68
Reimbursements	$257	$288	$290	+$2
Total, Program Level	$2,241	$2,342	$2,412	+$70
FTE	14,401	14,415	14,415	0

* Funds for the utility cost of health facilities ($12 million) are transferred from Clinical Services to Facilities & Environmental Health Support between FY 1997 and FY 1998.

Centers for Disease Control and Prevention

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Budget Authority	$2,144	$2,302	$2,316	+14
Program Level	2,245	2,416	2,452	+36
Outlays	2,198	2,189	2,271	+82
FTE	6,398	6,404	6,404	0

Summary

The FY 1998 President's Budget request for the Centers for Disease Control and Prevention (CDC) provides a $2.3 billion level of spending.

CDC is the Federal agency responsible for disease and injury prevention and the promotion of good health. To fulfill its vision of "Healthy People in a Healthy World Through Prevention", CDC addresses the leading preventable health problems affecting Americans. In its fifty years of noteworthy accomplishments, CDC has made prevention not only a science, but a practical reality. CDC constantly strives to determine what prevention strategies work best, for what groups of people, in what situations, and at what cost, both personal and economical. As the Nation moves forward to provide cost effective health care, the importance of investments in prevention, becomes more evident every day.

Childhood Immunization

In response to disturbing gaps in immunization rates for young children in America, this Administration made its Childhood Immunization Initiative (CII) a priority. While childhood immunization rates are at an all time high of 75 percent, about 1 million children under age two still have not received the full series of vaccinations. The CII goal is to ensure that by the year 2000, at least 90 percent of all two-year olds receive the full series of vaccines, and that a system is in place to sustain high immunization coverage.

In FY 1998 the Administration will spend a total of $792 million on childhood immunization--$427 million on CDC discretionary programs and $365 million on the Vaccines for Children (VFC) entitlement program. With these funds, CDC will be able to assist States in the purchase of the same level of vaccines as the previous year. Major components of the CII are the resources provided to States and cities to purchase vaccines; to assure access to public health clinics; and to increase parental awareness of the need to immunize children.

As a result of these expansive efforts over

time, many grantees are now experiencing some slowness in their ability to fully expend resources. In FY 1998 CDC will reduce by $14 million the amount of infrastructure assistance extended to States, and still support the same level of activities. This one-time reduction should ameliorate the balance of unspent funds from previous years' awards.

In addition, the FY 1998 budget includes a proposal to halt, for one-year, the payment of excise tax on all vaccines purchased by CDC. This proposal is projected to save a total of $97 million in both the purchase of vaccines through the discretionary grant program and the entitlement VFC. The Vaccine Compensation Trust Fund is expected to remain in a surplus status, exceeding $1 billion, even after the impact of this legislative savings.

Today, the VFC program is going strong, with all 50 States participating in the program. Tremendous strides have been made since the program began in October, 1994. Enrollment of private providers has extended to over 28,000 sites with multiple providers, and to approximately 9,000 public clinics. Through these providers, as well as, Community Health Centers and Rural Health Clinics, VFC vaccines are made available to Medicaid, uninsured, underinsured, American Indian, and Alaska Native children at their first medical point of contact.

HIV/AIDS

A total of $634 million, is requested for CDC HIV/AIDS prevention programs. Through CDC's HIV Community Planning process, States and local governmental and non-governmental organizations are better able to conduct HIV education and prevention programs that are individually tailored to specific populations' needs. In FY 1998, CDC will target the additional $20 million requested, to reaching an estimated 200,000 injecting drug users as a critical risk group for prevention targeting.

More than one-third of all reported AIDS cases in the United States are associated directly or indirectly with injecting drugs users (IDU), their sex partners, and children whose mothers either inject drugs themselves or are high-risk sex partners of IDUs. In 1995 alone, 19,261 AIDS cases--a quarter of the year's total cases--were reported among IDUs. CDC will promote a wide variety of strategies to reach those substance abusers at risk. These include integration of substance abuse and HIV prevention activities, high quality outreach programs for IDUs with frequent contacts for continuity of prevention efforts, improved access to health care and social services, prevention of syringe-sharing among those who continue to inject, community mobilization to reduce drug use, and improved access to drug treatment. Key in this effort is the recognition that programs must be locally designed to be locally relevant.

Preventing New and Emerging Infectious Diseases

Over the last 50 years, significant progress was made in the prevention and control of many infectious diseases. Today this progress has been partially reversed, due to factors which include changes in human behaviors, dramatic increases in international commerce and travel, environmental change, and deterioration of our public health infrastructure, resulting in the emergence of drug resistant and new and resurgent bacteria, fungi, parasites and viruses.

CDC is seeking a total of $112 million for infectious disease activities. Of this amount a $15 million increase is included to continue implementation of the CDC national prevention strategy for addressing emerging infectious

disease threats. The FY 1998 request will provide financial and technical support to 23 State health departments for surveillance, epidemiologic and laboratory investigations, and educational programs on infectious diseases, including rapid identification and investigation of outbreaks and drug resistant diseases. CDC will continue to establish a National early warning surveillance network on detection of emerging disease threats.

This investment has the potential to reduce the burden of illness due to infections and reduce health care costs substantially. Infectious diseases remain the leading cause of death worldwide. Emerging infections contribute substantially to the ongoing burden of infectious diseases on the American public. Childhood ear infections, the leading cause of visits to pediatricians, increased 150 percent between 1975 and 1990. Direct and indirect costs of infectious diseases are staggering. For example, influenza produces direct medical costs approaching $5 billion and lost productivity of almost $12 billion per year. Hepatitis B virus infection costs over $720 million each year. These are illustrative costs. Clearly, infectious diseases contribute significantly to economic losses and days of disability in the United States.

Interagency Food Safety Initiative

A second component of CDC's infectious disease prevention focus is to ensure safety of the Nation's food supply. CDC, along with FDA and the U.S. Department of Agriculture, will develop an expanded "Early Warning System" to help detect and respond to outbreaks of food borne illnesses. An increase of $10 million is requested to increase the number of active food safety surveillance sites across the country to eight. These "sentinel" sites will be better equipped, the labs will be modernized, and have additional staff (disease detectives) in order to better trace outbreaks to their source. Other State laboratories will receive technology enhancements as part of this initiative.

In addition, a food borne disease electronic communication network will be developed. Through the sharing of information electronically, more rapid dissemination of data--including the digitized DNA "fingerprints" of infectious agents--will occur. CDC will also conduct extensive prevention effectiveness evaluations and enhance the scientific basis for prevention of food borne illnesses.

Chronic Diseases - Heart Disease/Diabetes

Chronic diseases, for example, heart disease, cancer and diabetes account for over 70 percent of deaths in the United States and are a major cause of disability. Prevention of these diseases and managing the progression once a person is afflicted can be done through eliminating behavioral risk factors, increasing health promotion practices, detecting disease early, and appropriately managing and treatment of the disease. The FY 1998 budget includes an additional $25 million to strengthen the Nation's response to chronic disease.

Specifically, CDC is seeking an additional $15 million to expand continuing efforts by States to prevent tobacco use among young people. Also, CDC national surveillance efforts will evaluate State-specific tobacco prevention and control efforts. CDC's efforts will be in concert with those of FDA, NIH, and SAMHSA. Over the next seven years, the goal is to reduce teenage use of tobacco by 50 percent. Total spending directed to tobacco prevention would increase from $ 21 million to $36 million.

Additionally, CDC is requesting an increase of $10 million to expand the National Diabetes Control Program. It is estimated that 8 million Americans are diagonosed to have diabetes, with

diabetes ranking as the seventh leading cause of death in the United States. With this increase, the CDC will strengthen State-based control programs, expand educational campaigns, conduct applied research on the care and treatment of patients, and maintain a national surveillance system. Total spending on diabetes control will increase from $26 million to $36 mllion.

Sexually Transmitted Diseases

The prevention and control of sexually transmitted disease (STDs) has been a long-standing partnership involving Federal, State, and local health authorities. In FY 1998, CDC is seeking a total of $111 million, or a $5 million increase over FY 1997 to support this partnership.

This increase will be used to provide added capacity to respond to the increasing rate of chlamydia infection in this country. Untreated infection in women often leads to upper genital tract infection or pelvic inflammatory disease (PID). Many women with PID become infertile. Model programs to prevent chlamydia have been successfully tested. The added funds will permit CDC to begin to replicate these intensive screening approaches in other States, and ultimately reduce the rate of costly reproductive health consequences.

Rape Prevention Activities

In FY 1998, CDC is requesting $45 million, a $10 million increase, to support States efforts in the prevention of rape. These funds are distributed through a formula and was first initiated as part of the Violent Crime Control and Law Enforcement Act of 1994. States use these fund to operate rape crisis hotline, conduct victim counseling, train professional staff who assist victims, and create educational programs for adolescents and young adults to cut future violent crimes.

Breast and Cervical Cancer

Almost all deaths from cervical cancer and an estimated 30 percent of deaths from breast cancer in women over age 50 are preventable through widespread use of mammography screening and Pap-testing. In FY 1998, CDC is seeking $142 million, an increase of $2.3 million, over FY 1997. These funds will continue the enhancement of State-based programs as part of the National Breast and Cervical Cancer Early Detection Program. This national effort is an aggressive response to ensure the delivery of successful screening services. This includes screening referral and follow-up services, quality assurance, public and private education, surveillance, and partnership developments. As of May 1996, over one million women have been screened through this program.

Health Statistics

Health statistics have become a major priority of the health community over the last several years, and data systems like those of the National Center for Health Statistics (NCHS) have become regarded as the fundamental building blocks of public health policy.

Through the NCHS, the federal government is able to ensure that adequate information exists to:

- Track changes in health and health care, particularly as major changes are occurring in private market and in Federal and State activities.
- Plan, target , and assess the effectiveness of public health activities.
- Identify health problems, risk factors, and disease programs.

- Assist public and private managers and providers understand trends and better anticipate the future direction in the health care system and health behaviors.

The FY 1998 request includes $89 million for the health statistics programs of NCHS. In the coming year the NCHS will be taking increased leadership in coordinating, streamlining and improving the timeliness of Federal health statistics. The NCHS Director, through the HHS Survey Integration Plan, will explore better ways to design surveys, fill data gaps, and improve the use and analysis of survey information. Specific steps of the Plan include linked and integrated samples of many surveys, questionnaires will be made more comparable, and field operations of surveys will be merged as needed.

The increase of $3 million requested for FY 1998 will be used to continue the full implementation of the National Health and Nutrition Examination Survey (NHANES). By using direct standardizing measurements, NHANES helps in measuring health conditions and risks of the Nation--an important tool for measuring the outcomes of our investments in research, prevention and treatment.

National Institute for Occupational Safety and Health (NIOSH)

The FY 1998 budget request contains a total of $180 million, an increase of $7.2 million over FY 1997. NIOSH works to determine the nature and extent of the occurrence and causes of work injuries and diseases in greatest need of prevention and intervention efforts.

Of the additional funds requested for FY 1998, $4.6 million will be used to fully implement and staff a new research laboratory in Morgantown, West Virginia. This research facility will maximize CDC's capacity to conduct research on the etiology of health problems, develop and evaluate new approaches to exposure assessment and interventions, and develop methods to communicate, to all involved, safety and prevention information.

An additional $2.5 million in FY 1998 will be targeted to conduct assessments and evaluate investigations into fatal losses of life among fire fighters. Far too many fire fighters are injured or die (105 died in 1995 alone) on the job. New strategies need to be developed to intervene and prevent these incidents.

CDC OVERVIEW

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Preventive Health Block Grants	$145	$154	$144	$-10
Rape Prevention	29	35	45	+10
Prevention Centers	8	8	8	0
Sexually Transmitted Diseases	105	106	111	+5
Immunization	468	468	452	-16
Less: Proposed excise tax savings	0	0	-25	-25
Subtotal, Immunization	468	468	427	-41
Infectious Diseases	62	88	112	+24
Food Safety (non-add)	(3)	(5)	(15)	(+10)
Tuberculosis	119	119	119	0
Cancer Registries	18	22	22	0
Heart Disease/Smoking	45	46	61	+15
Diabetes & Other Chronic Diseases	315	36	46	+10
Environmental Health	39	43	42	-1
Breast & Cervical Cancer	125	140	142	+2
Lead Poisoning	36	38	38	0
Injury	46	49	49	0
Occupational Safety & Health	161	173	180	+7
Epidemic Services	78	89	89	0
Health Statistics	77	86	89	+3
HIV/AIDS	584	617	634	+17
Toxic Substances Disease Registry	59	64	64	0
Building & Facilities	4	31	23	-8
Program Management	3	3	2	-1
Total, Program Level	2,245	2,416	2,452	+36
Less: Intra-Agency Transfers & Receipts	-101	-114	-136	-22
Total, BA	2,144	2,302	2,316	+14
FTE	6,398	6,404	6,404	0

National Institutes of Health

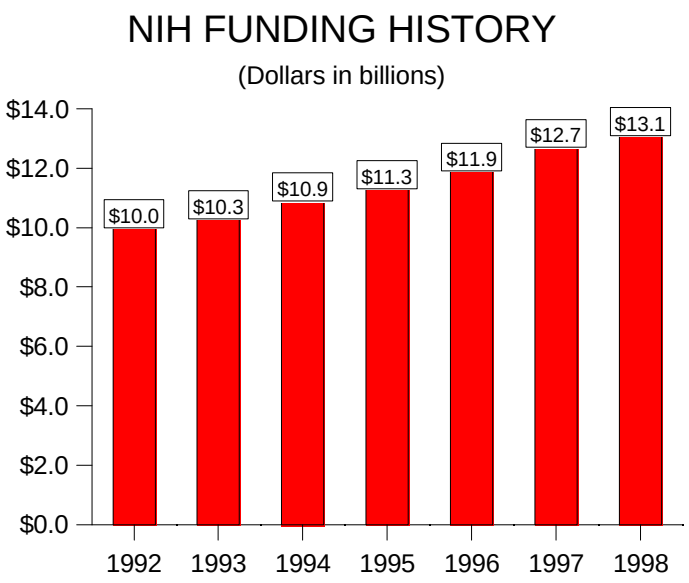
(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Budget Authority	$11,928	$12,741	$13,078	+$337
Program Level	$11,940	$12,754	$13,106	+$352
Outlays	$10,212	$12,146	$12,786	+$640
FTE	15,155	15,153	15,153	0

Summary

The FY 1998 request for the National Institutes of Health (NIH) totals $13.1 billion, an increase in new budget authority of $337 million, or 2.6 percent, over the FY 1997 level. Within this increase, $271 million is devoted to providing a 3.9 percent rate of growth in funding for research project grants, NIH's highest priority. In addition, $90 million in total is requested for the second phase of construction funding for NIH's new Clinical Research Center. The same as was provided in FY 1997.

Rational scientific research has given physicians the tools to treat, cure, and prevent diseases that, just a generation ago, were permanently disabling or fatal. In recent years, NIH-sponsored research has produced major advances in the treatment and management of cancer, HIV/AIDS, heart disease, diabetes, rheumatoid arthritis, and schizophrenia, to name just a few, which have helped to substantially decrease morbidity as well as considerably enhance the quality of life for both patients and their families. NIH has also made astonishing progress on the gargantuan task of mapping the human genome. The map, however, constitutes merely the first step in understanding the role genetic material plays in normal function and disease. With the map of the genome in hand, the next steps are to define the role each gene



plays in normal gene function, and the role a single gene or a combination of genes and their protein products play in disease. This knowledge will enable us to better recognize a disease, explain its pathogenesis, and ultimately cure it or prevent its onset.

NIH remains the preeminent biomedical and behavioral research enterprise in the United States. It also plays a singular role in nurturing and supporting the Nation's medical scientific research infrastructure, especially in biology and medicine, but also in chemistry, computer science, and other disciplines. This support has produced a comprehensive network of more than 50,000 scientists and technicians at more than 1,700 research universities, academic medical centers and institutions across the country. NIH's intramural scientists, in concert with its extramural partners, are responsible for generating an expanding foundation of new knowledge, which helps maintain the international dominance of our Nation's pharmaceutical and biotechnology industries.

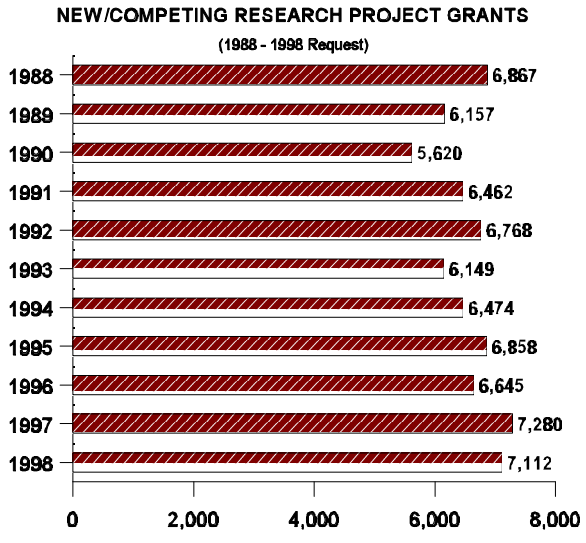
The Institutes and Centers funded by NIH's 24 appropriations are committed to supporting initiatives having the greatest potential for improving health, reducing the risk of disease, and ultimately, improving the quality of human life. For FY 1998, NIH has identified six medical research "areas of emphasis" in which opportunities abound in emerging technologies, approaches, and treatments that will expand the frontiers of medical knowledge and that offer great promise for curing disease and furthering the Nation's health. These "areas of emphasis" include research on the biology of brain disorders; on new approaches to pathogenesis, the study of disease origins and development; on new preventive strategies against disease; on genetics of medicine; on advanced instrumentation and computers in medicine and research; and on research on new avenues for therapeutics development, a new emphasis area for FY 1998 . NIH plans to devote an additional $223 million to such initiatives in FY 1998.

Research Project Grants

The support of basic medical research through investigator-initiated research project grants (RPGs) continues to be NIH's highest priority. These grants support new and promising ideas cutting across all areas of medical research. In FY 1998, the NIH budget provides nearly $7.2 billion to support another record total of 26,679 RPGs, including 7,112 new and competing RPGs. This represents an additional 939 total grants over FY 1997, a 3.6 percent increase. New and competing RPGs will be decreased by 168 in FY 1998, due to the cycling of new and competing grants from FY 1997 to noncompeting status.

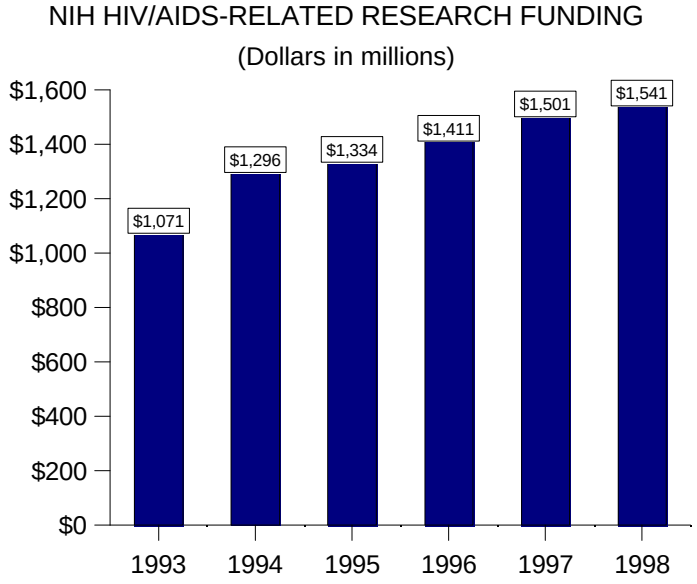
Office of AIDS Research

The FY 1998 President's budget again includes all of NIH's AIDS-related funds --



$1.5 billion -- in a single account for the Office of AIDS Research (OAR), consistent with the provisions of the NIH Revitalization Act of 1993. The Director of OAR will transfer funds to the Institutes in accordance with the comprehensive plan for AIDS research developed by the OAR along with the Institutes. The Administration strongly supports a consolidated AIDS appropriation within NIH as a vital part of ensuring a coordinated and flexible response to the AIDS epidemic.

The AIDS research effort is unlike any other program at the NIH in that it spans the agendas of every Institute and Center at NIH. Managing this complex and vast research portfolio requires a unique and unprecedented level of scientific leadership to determine research priorities and to ensure collaboration and minimize duplication in a united front against this devastating epidemic. The creation of the OAR has meant that there is



now a single entity solely devoted to directing and coordinating the entire NIH AIDS research program. The consolidated appropriation also gives the OAR the opportunity to reassess resource allocations across the Institutes based on scientific developments that may occur after the budget is developed.

The FY 1998 budget includes $1.5 billion for AIDS-related research in NIH. This is an increase of $40 million, or 2.6 percent, over the FY 1997 level. This is the same overall rate of increase as is requested for non-AIDS programs in total in FY 1998. The FY 1998 request represents a 44 percent increase in NIH's AIDS research funding since FY 1993. The request is based on scientific priorities which reflect a broad consensus of the current scientific opportunities, and the findings and recommendations of the NIH AIDS Research Program Evaluation Working Group. These priorities include: a rededication to fundamental science; a stronger effort to develop new vaccines; increased efforts to better understand the human immune system; emphasis on prevention science research, including microbicides; and a vigorous therapeutic research program.

Clinical Research Center

In FY 1998, a total of $90 million, plus advanced appropriations of $90 million in FY 1999 and $40 million in FY 2000, are requested to complete construction of the new Mark O. Hatfield Clinical Research Center. The current NIH Clinical Center is the core clinical research facility at NIH and the largest of its kind in the world. It provides protocol-specific patient care in support of the intramural research programs sponsored by most NIH Institutes, and serves as a resource for training clinical investigators. Each year, an average of 20,000 children and adults from across the country, and in some instances, the world, are referred to the Clinical Center for experimental treatment and study. These patients account for approximately 65,000 inpatient days and 70,000 outpatient visits a year. Nearly 1,000 clinical research protocols are ongoing at

the Clinical Center at any one time. This represents approximately 25 percent of all Federally funded outpatient visits associated with clinical research and nearly half of all the Federally funded clinical research beds in the Nation. Funds for the operations of the Clinical Center are derived from assessments on the participating Institutes and Centers.

In FY 1997, Congress provided the first $90 million of the total $310 million cost of replacing the existing 500-bed hospital of the Clinical Center, which is more than 40 years old, physically deteriorated, and nearly functionally obsolete. The new, state-of-the-art, 250-bed hospital and associated laboratories will be more efficient to run, more affordable to maintain, more flexible to staff, and more readily adaptable to the clinical research challenges of the future. The $90 million requested to be used in FY 1998 would provide for the second installment of construction funds.

The President's budget also requests advance appropriations for the third and fourth phases of construction funding for FYs 1999 and 2000 ($90 million and $40 million, respectively). The request for advance appropriations is in keeping with Administration policy and budget scoring agreements to fully account for the costs of major construction projects in budget requests, while not reducing funding available for research. These advance appropriations will not count against the Department's budget targets in FY 1998.

Other Priorities

Within the total $337 million increase requested for NIH in FY 1998 is an additional $30 million for research on drug abuse and drug treatment and prevention within the National Institute on Drug Abuse (NIDA). This 9 percent increase is part of the Administration's coordinated approach to combatting drug abuse.

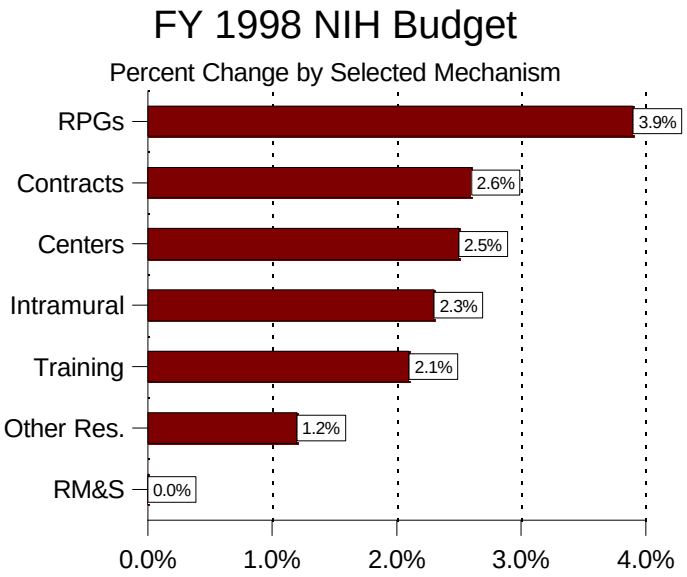
Additional funds will be directed to the areas of neuroscience research and understanding the role of brain functioning in the development and consequences of addiction; the development and application of new technologies, including imaging; research on the role of drug abuse as the primary vehicle for HIV/AIDS transmission; the medications development program; behavioral research; and prevention research. The development of a medication for the treatment of cocaine addiction is NIDA's highest priority for FY 1998.

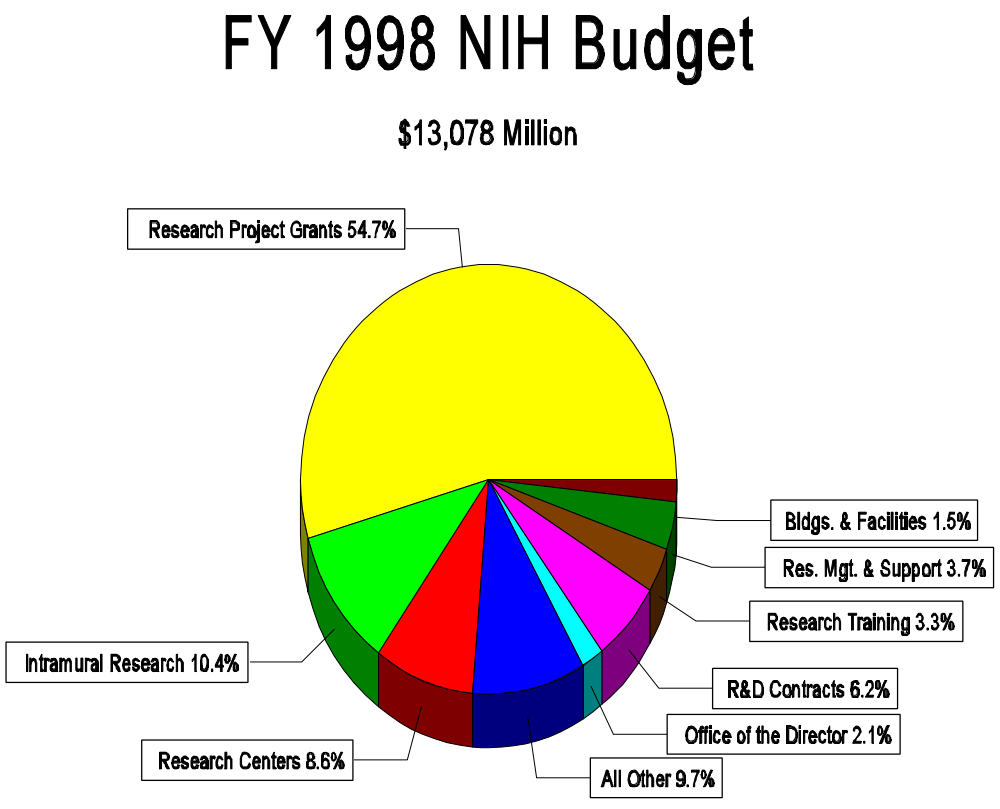
In addition, in conjunction with the Department's youth tobacco prevention initiative, in FY 1998, the National Cancer Institute (NCI) will extend, with full funding, for one full year its support of its current American Stop Smoking Intervention Study (ASSIST) contracts. The ASSIST program, for which NCI has supported the intervention phase since FY 1993, represents a collaborative effort among the NCI, the American Cancer Society, State and local health departments, and other voluntary organizations to develop comprehensive tobacco control programs in 17 States across the United States. More than 3,000 community organizations have joined ASSIST coalitions in the 17 States. The full-year extension in FY 1998 will carry the operations and infrastructure of these projects through to the end of FY 1999. Between now and then, NCI will be working with its Departmental and external partners to determine the most effective way to support and manage future tobacco prevention efforts as we move beyond the research phase of ASSIST and transition to the essential task of supporting disseminated tobacco prevention and control programs in public health.

Other Research Mechanisms

In FY 1998, NIH plans to increase spending for research training by $9 million over FY 1997, a 2.1 percent increase. This will allow NIH to support over 15,000 individual and institutional full-time research training positions. Within this increase, NIH will provide for the second year of an increase in training stipends of 3.5 percent for post-doctoral fellows with less than two years of experience.

Most other non-RPG research mechanisms will increase by about 2 percent in FY 1998, reflecting NIH's emphasis on the investigator-initiated RPG mechanism. Funds for research management and support costs are being straightlined from the FY 1997 levels.





NIH OVERVIEW (by Institute/Center)

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Institute:				
NCI	$2,030	$2,156	$2,217	+$61
NHLBI	1,294	1,371	1,405	+34
NIDR	170	183	190	+7
NIDDK	757	803	821	+18
NINDS	660	702	723	+21
NIAID	572	609	634	+25
NIGMS	918	971	992	+21
NICHD	532	567	582	+15
NEI	304	323	331	+8
NIEHS	282	302	314	+12
NIA	452	484	495	+11
NIAMS	240	253	259	+6
NIDCD	174	186	192	+6
NIMH	566	604	630	+26
NIDA	305	328	358	+30
NIAAA	188	201	208	+7
NINR	51	54	56	+2
NHGRI	168	187	202	+15
NCRR	321	341	334	-7
FIC	16	16	17	+1
NLM	150	161	166	+5
OD	233	251	234	-17
OAR	1,411	1,501	1,541	+40
Third Party Reimbursements	--	--	15	+15
Subtotal	$11,794	$12,554	$12,916	+$362
B&F	146	200	190	-10
Subtotal, Program Level	$11,940	$12,754	$13,106	+$352
Offsets:				
NLM User Fees	-$12	-$13	-$13	--
Third Party Reimbursements	--	--	-15	-$15
Total, BA	$11,928	$12,741	$13,078	+$337
FTE	15,155	15,153	15,153	0

NIH OVERVIEW (by Mechanism)

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Mechanism:				
Research Project Grants	$6,423	$6,884	$7,155	+$271
[No. of Non-competing]	*[17,854]*	*[18,460]*	*[19,567]*	*[+1,107]*
[No. of New/Competing]	*[6,645]*	*[7,280]*	*[7,112]*	*[-168]*
[Total No. Of Grants]	*[24,499]*	*[25,740]*	*[26,679]*	*[+939]*
SBIR/STTR Grants	$189	$246	$253	+$7
Centers	1,040	1,093	1,121	+28
Research Training	395	418	427	+9
R&D Contracts	765	789	809	+20
Intramural Research	1,296	1,333	1,364	+31
Other Research	793	861	854	-7
Research Management and Support	480	479	479	--
National Library of Medicine	153	164	169	+5
Office of the Director	260	287	270	-17
Buildings and Facilities	146	200	190	-10
Third Party Reimbursements	--	--	15	+15
Subtotal, Program Level	$11,940	$12,754	$13,106	+$352
Offsets:				
NLM User Fees	-$12	-$13	-$13	--
Third Party Reimbursements	--	--	-15	-$15
Total, BA	$11,928	$12,741	$13,078	+$337
FTE	15,155	15,153	15,153	0

Substance Abuse and Mental Health Services Administration

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Budget Authority	$1,885	$2,171	$2,206	+$35
Program Level	1,885	2,171	2,206	+35
Outlays	2,084	1,892	2,089	+197
FTE	592	592	592	0

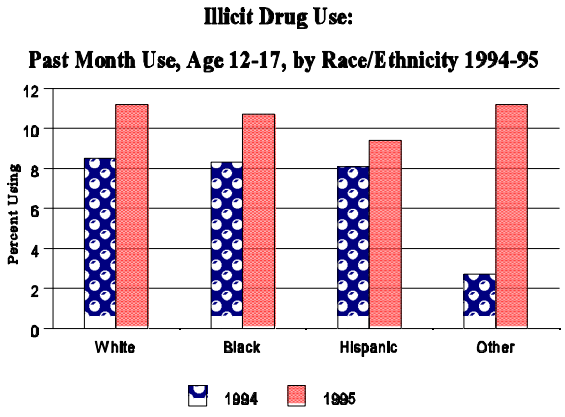
Summary

The FY 1998 President's budget for the Substance Abuse and Mental Health Services Administration (SAMHSA) totals $2.2 billion, an increase of $35 million or 1.5 percent over the FY 1997 enacted level. This request dedicates additional resources to substance abuse -- a $10 million increase is requested for the Substance Abuse Performance Partnership Block Grant, and an additional $28 million is requested for data collection activities to expand the National Household Survey on Drug Abuse (NHDSA) to individual States. The FY 1998 request continues to pursue legislation for both the substance abuse and mental health block grant programs to increase State flexibility and to build State performance data capacity.

A major component of SAMHSA's discretionary resources are included within the Knowledge Development and Application (KDA) program. Each of the KDA initiatives contains very concrete and focused activities designed to achieve real change. Development activities includeknowledge generation in the areas of Managed Care, Early Childhood Problems, and Improving Community Services. Application activities include State incentive grants that will be awarded in coordination with all substance abuse resources to develop an effective, comprehensive strategy aimed at reducing drug use by youth.

Teenage Drug Use

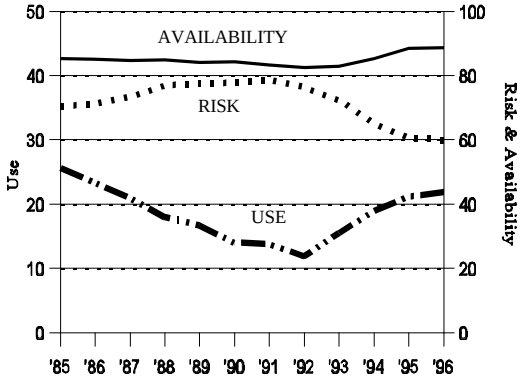
America is at a critical juncture in the fight



National Household Survey on Drug Abuse, SAMHSA, 1995

against drugs. A generation of young people do not think drugs and alcohol are dangerous, let alone illegal and just plain wrong. Many sectors of society are sending children conflicting and dangerous messages. In 1992, the rate of past month use of illicit drugs among 12-17 years old reached a low of 5.3 percent, a decline from 16.3 percent in 1979, according to the National Household Survey on Drug Abuse (NHSDA). By 1995, however, this rate stood at 10.9 percent. In the ongoing Monitoring the Future (MTF) study, illicit drug use among school children rose again in 1996. Of particular concern, is the continuing rise in daily marijuana use. At the low point in 1992, only 22 percent of high school seniors said they had used marijuana in the prior 12 months. By 1996, however, the rate had climbed back to 36 percent. Among eighth graders, annual prevalence (use in the prior 12 months) tripled from 6 percent in 1991 to 18 percent in 1996. The perceived risk of using marijuana continues to decline, while perceived risk of using other drugs either increased or remained level. In addition, reaching teenagers has been particularly problematic because of parental attitudes toward marijuana. Findings from a survey conducted by the National Center on Addiction and Substance Abuse (CASA) at Columbia University on teens' and their parents' attitudes on illegal drugs found that many parents appear resigned to such widespread drug use by their teenage children--46 percent of all parents expected their teens to experiment with illegal drugs, while 65 percent of those parents surveyed who regularly had used marijuana in their youth believe their teens will try drugs.

Marijuana: Trends in Availability, Perceived Risk, and Past 30 day Use for 12th Graders



Use: % using once or more in past 30 days (on left-hand scale)

Risk: % saying great risk of harm in regular use (on right-hand scale)

Availability: % saying fairly easy or very easy to get (on right-hand scale)

Monitoring the Future Survey, NIDA, 1996

Youth Substance Abuse Prevention Initiative

The 1998 budget request continues to expand funding for the Youth Substance Abuse Prevention Initiative. This proposal directly addresses Goal #1 of the National Drug Control Strategy to *"motivate America's youth to reject illegal drugs as well as the use of alcohol and tobacco."* To best respond to increasing teen substance abuse, this initiative will incorporate three interrelated components:

- State Incentive Grants: Nearly $63 million in FY 1998 will be directed toward mobilizing and leveraging Federal and State resources to call upon Governor's to develop State-wide prevention plans that work. States will take state-of-the-art prevention models and approaches and replicate or adapt them for their communities. More importantly, States will be required to report both baseline data and post-program measures of success.

- Mass Media/Public Campaign: SAMHSA is requesting $4 million for a broad based effort to raise public awareness and counter pro-drug use messages. This campaign would be coordinated with major effort by the Office of National Drug Control Policy (ONDCP),

private partners such as the National Partnership for a Drug-Free America, and other major groups and organizations. Efforts will focus on the family and will include parents as a prime target audience of the Initiative's campaign;

- Data Collection: An additional $28 million in FY 1998 is requested to expand the National Household Survey on Drug Abuse to increase accountability through data system development. Given the substantial Federal resource investment in the Youth Substance Abuse Prevention Initiative, it is imperative that National and State data be available regarding progress in achieving desired objectives and outcomes. The systematic collection of data on a permanent basis represents an important surveillance mechanism for tracking substance abuse trends among the teenage population. The success of these efforts will be measured by national as well as State indicators of youth drug attitudes and use. Outcome measures include increases in social disapproval among youth, increases in perception of harm, decreases in drug abuse related outcomes (e.g., emergency room visits and crime), and decreases in drug use by youth. Additionally, State level data will assist in the design and operation of substance abuse activities tailored to specific populations' needs.

Mental Health Services

The mental health world is changing rapidly and dramatically in the ways services are organized, financed, and provided. For instance, managed mental health care is now covering more than 124 million persons. The FY 1998 budget request of $445 million supports the Federal government's role in the mental health services field. The Center for Mental Health Services (CMHS) is working with States, professional organizations, consumers and other groups to assess the impact of managed care and to devise strategic solutions to these momentous changes.

The FY 1998 request maintains most CMHS programs at the FY 1997 enacted level. Included in the request is $275 million for the Mental Health Block Grant and $70 million for Children's Mental Health Services. This request also supports Knowledge Development and Application activities. These activities are responsible for producing new knowledge and application information like the Knowledge Exchange Network -- a national center that disseminates the most up-to-date mental health system and services research and referral services to the public.

SAMHSA OVERVIEW

(dollars in millions)

	1996 Actual	1997 1/ Enacted	1998 Request	Request +/- Enacted
Substance Abuse:				
Knowledge Development and Application . .	$182	$312	$307	$-5
Prevention	*(92)*	*(156)*	*(151)*	*(-5)*
Treatment	*(90)*	*(156)*	*(156)*	*(0)*
Substance Abuse Block Grant/PPGs	1,234	1,310	1,320	+10
Data Collection Initiatives	- - -	- - -	28	+28
Subtotal, Substance Abuse	**$1,416**	**$1,622**	**$1,655**	**+$33**
Mental Health:				
Knowledge Development and Application . .	38	58	58	*0*
Mental Health Block Grant/PPGs	275	275	275	0
Children's Mental Health Services	60	70	70	0
Protection and Advocacy	20	22	22	0
PATH	20	20	20	0
Subtotal, Mental Health	**$413**	**$445**	**$445**	**0**
Buildings and Facilities	- - -	- - -	1	+1
Program Management	56	54	55	+1
Total, Discretionary BA	**$1,885**	**$2,121**	**$2,156**	**+$35**
Advance Appropriation P.L. 104-121 2/	- - -	*50*	*50*	*0*
Program Level	**$1,885**	**$2,171**	**$2,206**	**+$35**
FTE	**592**	**592**	**592**	**0**

1/ Reflects the comparable transfer to the Administration for Children and Families of $12.8 million for the Community Schools Program.

2/ The additional $50 million available through the Substance Abuse Block Grant is a result of P.L. 104-121, and is designated as mandatory spending for treatment services for SSI recipients.

Agency for Health Care Policy and Research

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Budget Authority	$65	$96	$87	-9
Program Level	125	143	149	+6
Outlays	81	95	88	-7
FTE	252	252	252	0

Summary

The FY 1998 request for the Agency for Health Care Policy and Research (AHCPR) provides a program level of $149 million.

AHCPR directly contributes to improving the management of this nation's health care enterprise. Results of its health services research and clinical practice guidelines are used every day by health care providers working to improve quality of care while managing the financial bottom line. Its data collection and analysis are important to health policy analysis and help guide the decisions made by those steering the future of this nation's health care industry.

AHCPR works in partnership with the private sector in determining which medical interventions work best and provide the most value for our health care dollar in the day-to-day practice of medicine. In addition, AHCPR research addresses the effectiveness and cost-effectiveness of the organization, financing, and delivery of health services.

FY 1998 Request

The budget request of $149 million is composed of $87 million in direct appropriations and $62 million in inter-agency transfers. At this level, AHCPR will be able to provide the information, the expertise, and the tools required to continue to improve the health care system and improve the effectiveness and appropriateness of health care.

The Research on Health Care Systems Cost and Access program which is funded at $47 million in FY 1998 develops the analyses and tools needed to improve the functioning of the health care system. This research identifies the most effective and efficient approaches to organize, deliver, finance, and reimburse health care services; determines how the structure of the delivery system, financial incentives, market forces, and better information affect the use, quality, and cost of health services; and facilitates the translation of research findings for the use of key participants in the health care

system, particularly providers, plans, purchasers, and policy makers. A major initiative to assist consumers in selecting high quality health plans and services will be continued. This project, the Consumers Assessments of Health Plans Study will include consortia participation by the Research Triangle Institute, the RAND Corporation and Harvard Medical School.

AHCPR's Health Insurance and Expenditure Surveys which totals $36 million FY 1998, provide public and private sector decision makers with the ability to obtain timely national estimates of health care use and expenditures, private and public health insurance coverage, and the availability, costs, and scope of private health insurance benefits among the U.S. population. This activity also provides analysis of changes in behavior as a result of market forces or policy changes on health care use, expenditures, and insurance coverage; develops cost/savings estimates of proposed changes in policy; and identifies the impact of changes in policy for key subgroups of the population (i.e. who benefits and who pays more). Currently, these objectives are accomplished through the fielding of the Medical Expenditure Panel Surveys (MEPS). Analytic work on the data collection will begin this year and is expected to be completed by FY 2001. Additionally, the MEPS will change from a periodic annual survey, coverting to an ongoing continuous survey.

The Research on Health Care Outcomes and Quality Program totals $64 million in FY 1998, an increase of $16 million over FY 1997. Through this program AHCPR determines what works best in medical care to increase the cost-effectiveness and appropriateness of clinical practice; supports the development of tools to measure and evaluate health outcomes, quality of care, and consumer satisfaction with health care system performance; and facilitates the translation of information into practical uses through the development and dissemination of tools for clinical improvement, information technology, and strategies for provider and patient education.

AHCPR is currently in the process of soliciting priorities for the next phase of research. Topics already identified include Hormone Replacement Therapy, Alzheimer's Disease, common orthropedic conditions, (e.g. carpal tunnel syndrome) and clinical conditions that are common in children and adolescents.

A second part of AHCPR's initiative is to support studies which help assess the best strategies for bringing about change in clinical performance. A component of this latter area of emphasis will be the support of Evidence-based Practice Centers. The Centers will synthesize information and work with the end-users on how best to ensure the usefulness of quality improvement strategies.

AHCPR OVERVIEW

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Research on Health Care	$56	$48	$64	+$16
Systems Cost and Access	52	48	47	-1
Health Insurance & Expenditure Survey	15	45	36	-9
Program Support	2	2	2	0
Subtotal, Program Level	125	143	149	+6
Less Transfers: PHS Intra-agency	-60	-47	-62	-15
Total, BA	65	96	87	-9
FTE	252	252	252	0

Health Care Financing Administration

(dollars in millions)

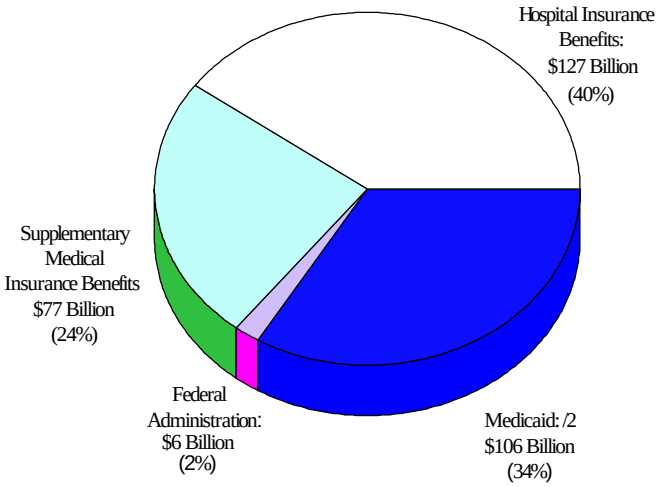
	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Budget Authority	261,777	295,203	310,371	15,168
Outlays	266,152	292,718	315,318	22,600
FTE	4,081	4,085	4,085	0

Summary

The FY 1998 budget request for the Health Care Financing Administration (HCFA) is $315.3 billion (net of offsetting receipts) for Medicare and Medicaid benefits and operating costs, an increase of $22.6 billion over FY 1997 (see Figure 1 for the distribution of spending). Spending for the Medicare and Medicaid programs represent 84 percent of the total HHS budget for FY 1998.

The Medicare and Medicaid budget includes legislative proposals that reduce spending by $2.9 billion in FY 1998 ($109.5 billion over the next 5 years) and ensure that these programs can continue to provide needed health services into the next century. Medicare and Medicaid combined will pay for the health care costs of aproximately 71 million elderly, disabled and economically disadvantaged Americans in FY 1998 (individuals eligible for both Medicare and Medicaid are not double counted in this figure). Slightly more than a quarter of all Americans will receive Medicare or Medicaid services in FY 1998.

HEALTH CARE FINANCING ADMINISTRATION
FY 1998 NET OUTLAYS
$315 Billion/1



/1 Numbers may not add due to rounding
/2 Includes benefits and State and local administration

MEDICARE

Summary

Medicare is a Federal health insurance program for people age 65 or older and people under age 65 who are disabled or suffer from end-stage renal disease (ESRD). In FY 1998, the program will serve approximately 39 million eligible individuals. Medicare consists of two parts:

- Part A--Hospital Insurance (HI) Pays for inpatient hospital care, some skilled nursing facility care, home health care and hospice care. The HI program is funded through the HI Trust Fund. The Trust Fund receives most of its income from the HI payroll tax (2.9 percent of payroll, split between employers and employees).

- Part B--Supplementary Medical Insurance (SMI) Pays for medically necessary physicians' services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment and certain other medical services and supplies. The SMI program is funded through the SMI Trust Fund. The Fund receives income primarily from two sources: a general revenue transfer and premiums paid by enrollees.

Preserving and Modernizing Medicare

The 1998 budget preserves and modernizes Medicare, extending the solvency of the Part A Hospital Insurance Trust Fund to 2007. This budget, like the President's previous two budgets, gives beneficiaries more choices among private health plans, makes Medicare more efficient and responsive to beneficiary needs, reduces the rate of growth in provider payments, and holds the Part B premium at 25 percent of program costs.

The President's 1998 budget builds on his 1997 budget. Last year, we wanted to ensure the solvency of the Part A Trust Fund for 10 years. According to the Chief Actuary at the Health Care Financing Administration, the Medicare policy in this budget will extend the solvency of the Trust Fund to 2007.

Last year, we wanted to restrain provider payments at a level that would continue to ensure the quality of access to care. This year, we believe that we can restrain provider payments -- particularly in the areas of managed care and hospitals -- more than we did last year, without harming quality and access.

Last year, we wanted to protect beneficiaries from major new out-of-pocket expenditures and allow them to take advantage of advances in preventive care. This year, we continue to adhere to this principle by keeping the Part B premium at 25 percent of program costs and by proposing new preventive health benefits.

The Medicare policy in our 1998 budget is similar in many ways to our policy last year. However, there are several policy changes of note, in particular with regard to payment rates for managed care, hospital outpatient prospective payment, and competitive bidding for laboratory services and durable medical equipment.

Payment Reforms and Program Savings

- **Beneficiaries:** The 1998 budget proposes a number of changes in law that affect beneficiaries, including new benefits, Medigap protections, and proposals to increase beneficiary choice. The 1998

budget will propose extending current law that sets the Part B premium at 25 percent of program costs. This policy achieves $10 billion in savings over five years ($18 billion over six years). Without this policy, the Part B premium would drop below 25 percent after 1998.

- **Hospitals:** The proposals in the 1998 budget relating to hospitals will reduce the annual inflation increase, or "update," for hospitals; reduce payments for hospital capital; reform payments for graduate medical education; and implement prospective payment for outpatient departments while protecting beneficiaries from increasing charges for those services. The budget will propose to achieve $33 billion in net savings over five years ($46 billion over six years).

- **Managed Care:** There is substantial evidence that Medicare pays too much for managed care plans and actually loses money, on average, for every beneficiary who opts for managed care. The new policy proposals will reduce reimbursements to managed care plans by about $34 billion over five years ($46 billion over six years). Savings will come from three sources:

(1) Reducing reimbursement to managed care plans from its current rate of 95 percent of fee-for-service rates to 90 percent starting in FY 2000. This accounts for $6 billion in savings over five years (about $8 billion over six years).

(2) Indirect savings of $18 billion over five years (and $25 billion over six years) attributable to cuts in the traditional fee-for-service side of the program. Because HMO payments are based on a percentage of fee-for-service payments, projected HMO payments will be reduced as a function of our proposed cuts in the fee-for-service side of the program.

(3) A carve-out of medical education and uncompensated care payments from the HMO reimbursement formula to be paid directly to academic health centers and to HMOs that run their own residency programs. This aspect of the plan would reduce direct managed care payments by $10 billion over five years (and $13 billion over six years).

- **Physicians:** The budget will propose to save about $7 billion over five years (about $10 billion over six years) by establishing a single update for all physicians and replacing the current "volume performance standards" with a sustainable growth rate. This reduction is relatively small because Medicare has been fairly effective in constraining growth in reimbursement to physicians.

- **Skilled Nursing Facilities:** The FY 1998 budget will propose to save about $7 billion over five years ($9 billion over six years) through the establishment of a prospective payment system. This benefit has been growing at double-digit rates, and there is a consensus that moving to prospective rates will help contain costs.

- **Home Health Care**: Home health care has become one of the fastest growing components of the Medicare program, growing at double digit rates. To help control this growth, the budget proposes payment reforms leading to a new prospective payment system for home health. Together, these proposals will save $14 billion over five years ($18 billion over six years), and are included in our total

Medicare savings estimate of $100 billion over five years (and $138 billion over six years).

The home health program was originally designed as a post-acute care service for beneficiaries who had been hospitalized. However, over time, home health care has increasingly become a chronic care benefit not linked to hospitalization. Under the President's proposal, the first 100 home health visits following a 3-day hospitalization would be reimbursed by Part A. All other visits -- including those not following hospitalization - would be reimbursed by Part B. This provision is similar to a provision in a Medicare reform bill the House passed in 1995.

This proposal does not yield budget savings. The $100 billion five-year savings and the $138 billion six-year savings include no contribution from the home health reallocation. In addition, beneficiaries will not be affected by this restoration of the original policy. The policy avoids the need for excessive reductions in payments to hospitals, physicians, and other health care providers while helping to extend the solvency of the Part A Trust Fund.

- **Anti-Fraud and Abuse:** The budget proposes strong fraud and abuse provisions, including measures to eliminate fraud in home health care -- such as by ensuring that home health agencies are reimbursed based on the location of the service, not the billing office. The budget also would repeal several provisions in last year's health reform law that weakened anti-fraud enforcement. The anti-fraud initiatives in the budget will save $9 billion over five years ($12 billion over six years).

Provisions to Improve Rural Health Care

The budget proposes to expand access to, and improve the quality of, health care in rural areas. It extends the Rural Referral Center program; allows direct Medicare reimbursement for nurse practitioners and physician assistants; improves the Sole Community Hospital program; and expands the Rural Primary Care Hospital program. Finally, the plan proposes a payment floor for managed care plans in rural areas.

Program Improvements that Expand Choices and Add Preventive Benefits

The budget proposes new private plan choices - through new Preferred Provider Organizations (PPO) and Provider Sponsored Organizations (PSO) -- for beneficiaries. The budget also encourages more choices through new Medigap protections (such as new open enrollment requirements and prohibitions against the use of pre-existing condition exclusions) to increase the security of Medicare beneficiaries who wish to opt for managed care but fear they will be unable to obtain Medigap insurance if they decide to return to fee-for-service plans.

The budget also proposes new preventive health care benefits to improve the health of older Americans and reduce the incidence of disease. The plan covers colorectal screening, diabetes management, and annual mammograms without copayments. It also increases reimbursement rates for certain immunizations to ensure that seniors are protected from pneumonia, influenza, and hepatitis. The budget will also propose a new Alzheimer's respite benefit starting in 1998 to assist families of Medicare beneficiaries with Alzheimer's disease. Total beneficiary investments in the budget will cost $13 billion over five years ($22 billion over six years).

MEDICARE OVERVIEW

(Beneficiaries in millions)

	1996	1997	1998	+/-
Persons Enrolled:				
Hospital Insurance (HI)	37.7	38.1	38.6	+0.5
Supplementary Medical Insurance (SMI)	36.0	36.5	36.9	+0.4

(Outlays in millions)[1]

	1996 Actual	1997 Enacted	1998 Request	Total 1998-2002
Current Law:				
HI Benefits	$124,088	$136,278	$147,433	$863,955
SMI Benefits	67,176	74,937	82,470	503,519
Subtotal, Medicare Benefits (includes PROs)	$191,264	$211,215	$229,903	$1,367,474
Health Care Fraud & Abuse Control	$0	$521	$596	$3,680
HCFA Admin/Research	2,096	1,839	1,774	8,819
SSA/Non-HCFA Admin	894	897	1,015	4,980
Subtotal, Admin	$2,990	$3,257	$3,385	$17,479
Total Outlays, Current Law	$194,254	$214,472	$233,288	$1,349,995
Offsetting Receipts[2]	$-20,086	$-20,293	$-21,983	$-120,646
Total Net Outlays, Current Law	$174,168	$194,179	$211,305	$1,229,349
Proposed Legislation:				
HI Savings	$0	$0	$-19,410	$-161,420
SMI Savings	0	0	14,889	69,861
Offsetting Receipts2[2]	0	0	211	-8661
Total Medicare Savings	$0	$0	$-4,310	$-100,220
Total, Net Outlays, Proposed Law	$174,168	$194,179	$206,995	$1,129,129

1 Numbers may not add due to rounding.
2 Offsetting collections in program management and premiums collected from beneficiaries under Medicare HI and SMI.

MEDICAID

Summary

In FY 1998, Medicaid will provide grants to States for the medical care of about 38 million low-income individuals. Under current law, the Federal share of Medicaid payments is expected to reach $104 billion in FY 1998. This is a $5.9 billion (6 percent) increase over projected FY 1997 spending. The President will submit a comprehensive Medicaid reform package, which provides States with additional program flexibility, while preserving the guarantee of health and long-term care coverage for the most vulnerable Americans.

Enhancing State Flexibility

States have considerable flexibility in structuring the Medicaid program, including determining provider payment rates, certification standards, and developing alternative health care delivery programs. In addition, waivers from various portions of the broad Federal guidelines are also available to States.

Freedom-of-choice waivers allow States to enroll beneficiaries in cost-effective systems of care, such as case management and competitive bidding arrangements. Home and community-based service waivers allow States to cover community-based care as an alternative to institutionalization.

States have also restructured eligibility and coverage under Medicaid through the use of Section 1115 demonstration waivers. Under these demonstrations, States acquire savings by incorporating managed care concepts, redirecting uncompensated care payments, and consolidating State health programs. States use these savings to expand coverage to previously uninsured populations. States are using Section 1115 waivers to reform health care by expanding coverage without increasing the amount the Federal Government would have otherwise spent. Since 1993, this Administration has approved fifteen Section 1115 demonstrations, and is committed to working cooperatively with additional States to support innovative ideas. Delaware, Hawaii, Minnesota, Ohio, Oklahoma[1], Oregon, Rhode Island, Tennessee, and Vermont are currently operating approved demonstrations, extending health care coverage to about 672,000 Americans who were otherwise not covered by health insurance. Alabama, Florida, Illinois, Kentucky, Maryland, and Massachusetts have approved waivers but have not begun operation of their demonstrations. Once fully implemented, these fifteen demonstrations could extend coverage to 2.2 million individuals, at no increased cost to the Federal Government.

Legislative Proposal

The FY 1998 President's Budget would produce a net savings to Medicaid of $9 billion from 1998-2002. The budget also makes a number of improvements to the Medicaid program, including changes to last year's welfare reform law, costing $13 billion over the same period. These costs are more than offset by the $22 billion in Medicaid savings from FY 1998-2002 from a combination of policies that would impose a per capita cap on spending and reduce Disproportionate Share Hospital (DSH) payments.

To allow States to better manage their Medicaid programs under the per capita cap limit, the budget would give States substantially increased flexibility such as allowing managed care without waivers. Finally, this plan retains

[1] Oklahoma has no expansion population in its 1115 waiver.

current nursing home quality standards and continues to protect the spouses of nursing home residents from impoverishment.

The President's Medicaid reform proposal makes other changes to give States more flexibility in managing their Medicaid programs. Changes include:

- **Coverage for Children:** The plan lets States provide continuous coverage for one year after eligibility is determined, guaranteeing more stable coverage for children and more continuity of health care services.

- **Boren Amendment:** The plan repeals the so-called "Boren amendment," eliminating Federal provider payment requirements for hospitals and nursing homes.

- **Managed care**: The plan allows States to mandate enrollment in managed care systems without going through the Federal waiver process.
- **The Working Disabled:** The plan lets States establish an income-related premium buy-in program under Medicaid for people with disabilities who work. It would let eligible Supplemental Security Income beneficiaries who earn more than certain amounts purchase Medicaid coverage by paying a premium that States would set on an income-related sliding scale.

Background

Medicaid is a voluntary program, initiated and administered by the States. State expenditures for medical assistance are matched by the Federal Government using a formula based on per capita income in each State relative to the national average. Matching rates for FY 1997 are projected to range from 50 to 77 percent for medical assistance payments and from 50 to 100 percent for administrative costs. The Federal matching rate on average is approximately 57 percent.

Historically, most individuals' eligibility for Medicaid has been based on qualifying under the cash assistance programs of Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). With passage of the new Temporary Assistance for Needy Families (TANF) program, which replaces AFDC, Medicaid and AFDC have been de-linked. Medicaid eligibility remains tied to AFDC program rules in place on July 16, 1996. All those who qualify under the 1996 AFDC rules and most SSI recipients, commonly referred to as the "categorically eligible," are covered under State Medicaid programs. States cover some individuals not eligible under AFDC or SSI rules (e.g., people with higher incomes in institutions, low-income pregnant women and children, and aged, blind, and disabled people below the poverty line). States may also cover "medically needy" individuals. Such individuals meet the categorical eligibility criteria, but have too much income or resources to meet the financial criteria.

States are required to provide a core of 13 mandatory services to all eligible recipients. Those mandatory Medicaid services include inpatient and outpatient hospital care, health screening, diagnosis, and treatment to children, family planning, physician services, and nursing facility services to individuals over 21. States may also elect to cover any of over 30 specified optional services, which include prescription drugs, clinic services, dental, eyeglasses, and services provided in intermediate care facilities for the mentally retarded.

Medicaid covers children under the age of six and pregnant women whose family income does not exceed 133 percent of the Federal poverty level. Medicaid coverage of children aged 6 through 18, born after September 30,

1983, whose family income does not exceed 100 percent of the Federal poverty level, is being phased in. By 2002, all children under the age of 19 living below the poverty level will be eligible for Medicaid. In addition, Medicaid pays Medicare premiums and cost sharing for Medicare coverage of certain low income seniors and disabled individuals eligible for Medicare, also referred to as Qualified Medicare Beneficiaries (QMBs). The President's Medicaid reform proposal would preserve these important protections and expansions.

Federal Medicaid outlays rose dramatically from FY 1989 through FY 1992, at a 25 percent average annual rate. However, outlay growth slowed to less than 12 percent in FY 1993, followed by 8 percent growth in FY 1994. Last year in FY 1996, Medicaid growth slowed to 3.3 percent. The decline in the rate of Medicaid increases is due to many factors, including legislative changes (such as limits on provider specific taxes and donations), decreases in the projected growth of SSI caseloads, and States' efforts to control costs. The President’s plan maintains these appropriate limitations.

MEDICAID OVERVIEW

(Recipients in thousands)

	1996	1997	1998	+/-
Beneficiaries*				
Aged 65 and Over	4,460	4,517	4,575	+ 58
Blind and Disabled	6,809	6,966	7,034	+ 68
Needy Adults	7,420	7,451	7,568	+117
Needy Children	17,484	17,611	17,916	+305
Other	633	633	633	+ 0
Unduplicated Total	36,805	37,177	37,727	+550

(Outlays in millions)

	1996 Actual	1997 Enacted	1998 Request	Total 1998-2002
Current Law:				
Benefits	$87,964	$93,346	$99,144	$573,670
State and Local Administration	3,813	4,912	4,981	28,313
Survey and Certification	137	163	172	963
State Medicaid Fraud Control Units	77	82	87	496
Total, Current Law Outlays[1]	$91,990	$98,503	$104,384	$603,442
Proposed Legislation:				
Medicaid Savings	$0	$39	$1,417	- $9,252
Total, Outlays[2]	$91,990	$98,542	$105,801	$594,190

1 Includes Vaccine for Children Outlays.
2 Numbers may not add due to rounding.

PROGRAM MANAGEMENT

Summary

HCFA's FY 1998 Program Management budget request is $1,775 million, a 2.3 percent increase over enacted FY 1997. The Program Management account provides resources for administering the Medicare and Medicaid programs. Program Management supports the following activities: Medicare Contractors, Federal Administration, Medicare Survey and Certification, and Research, Demonstrations and Evaluation.

While workloads have continued to increase every year, the Program Management budget, minus program integrity spending, has remained relatively flat, requiring HCFA to find more efficient methods to accomplish its goals as established in its strategic plan. HCFA is attempting to fulfill a significant part of this mission with the development and implementation of the Medicare Transaction System (MTS), HCFA's state-of-the-art information management initiative.

When fully implemented, MTS will consolidate the current system of 75 contractors utilizing eight shared systems, at over 30 operating sites, into one integrated information system operated by three contractors using standardized data elements. In addition to claims processing functions, MTS will merge managed care payments, beneficiary entitlement and insurance information. This initiative will achieve substantial administrative and program savings through the use of new technology, through the consolidation of Part A and Part B systems, and through standardized data. MTS will affect all aspects of Medicare, positioning HCFA to administer the program and to reengineer itself more productively for the challenging times ahead.

Medicare Contractors

The Medicare program is administered through private organizations, usually private insurance companies, which are referred to as contractors. Contractors' responsibilities include processing claims and making benefit payments, developing management improvements called productivity investments, and responding to the needs of many customers and stakeholders, the Medicare beneficiaries and the provider community.

Due to the enactment of the Health Insurance Portability and Accountability Act of 1996, HCFA's payment safeguards program has been replaced by a new mandatory program, the Medicare Integrity Program, also operated by contractors.

Despite a growing investment in MTS and an increasing claims workload, the Medicare Contractor budget will increase by only 1.3 percent, from $1,207.2 million in FY 1997 to $1,223.0 million in FY 1998 due to increased efficiencies. The key contractor activities are claims processing, beneficiary and provider services, and productivity investments.

Approximately 67 percent of the FY 1998 contractor budget request, or $824.2 million, has been designated for claims processing, a 2 percent decrease below FY 1997. HCFA's success in increasing electronic media claims submissions and in reducing the unit costs of processing claims will allow the agency to process an expected 889.1 million claims in FY 1998 within statutorily limited processing times. This workload level represents a nearly 4.3 percent increase over revised FY 1997 estimates. Beneficiary and provider services comprise approximately 20 percent of the

Medicare Contractors' FY 1998 request, or $253 million. This amount will maintain funding for the Medicare beneficiary toll-free telephone lines, timely hearings and reconsideration, prompt responses to provider and beneficiary inquiries, provider education and training efforts. HCFA will continue its innovative use of audio response units (ARUs) for telephone inquiries, as well as its use of the telephone to conduct hearing reviews and reconsideration. These activities demonstrate HCFA's combined efforts towards more cost-effective management and a greater commitment to providing better customer service.

The budget request allocates $145.6 million for productivity investments. Productivity investments enhance the cost-effectiveness and quality of contractor operations and are part of the long-term reform of Medicare administration. Included in this amount is $89 million for Medicare Transaction System (MTS) implementation. HCFA estimates that MTS will achieve $200 million in annual administrative savings and $500 million in program savings once fully implemented. Other productivity investments include transition costs for contractors who choose not to renew their contracts with Medicare.

The Health Insurance Portability and Accountability Act of 1996 establishes the new Medicare Integrity Program (MIP) within the Hospital Insurance Trust Fund's Health Care Fraud and Abuse Control Account. Under this new program, HCFA will procure new contracts to perform Medicare program integrity activities such as medical and utilization review, coordination of benefits, audits of health care providers, developing fraud and abuse cases, and educating providers on correct Medicare procedures. In FY 1998, the Act authorizes up to $500 million in spending for these important activities from which HCFA expects to yield $5.8 billion back to the Trust Funds.

Federal Administrative Costs

In FY 1998, the President's budget requests $359 million for HCFA's Federal administrative costs. This request also includes a staffing level of 4,085 FTE. HCFA remains on target to meet the Department's FTE targets, thereby supporting the President's mandate on reducing the size of the Federal workforce. This funding level also includes funding to support the extensive data processing requirements for the Medicare and Medicaid program, as well as necessary maintenance and enhancement of 80 automated data systems.

This funding level allows HCFA to successfully convert its internal computer systems for the millennium change providing $15 million for this effort. HCFA will also spend $5 million for work associated with its annual Chief Financial Officer's Act audit. Because of the size of both the Medicare and Medicaid programs in relation to the overall federal budget, it is important that HCFA's audit be properly performed to ensure the integrity of the overall Federal audit.

Research, Demonstrations and Evaluation

The FY 1998 budget requests $45 million for the Research, Demonstrations and Evaluation program. HCFA's research program supports research and demonstration projects to develop and implement new health care financing policies and to evaluate the impact of HCFA's programs on its beneficiaries, providers, States, and our other customers and partners. Information from HCFA's research program is used by Congress, the Executive Branch, and States to improve the efficiency, quality, and effectiveness of the Medicare and Medicaid programs.

In addition to basic research, this budget fully funds the Medicare Current Beneficiary Survey at approximately $10 million. Basic

research funds will support research and demonstration in the areas of monitoring health system performance, improving health care financing and delivery mechanisms, meeting the needs of vulnerable populations, and improving consumer choice and health status. HCFA will continue its commitment to rural health needs in FY 98 by supporting efforts for telemedicine demonstrations in rural areas.

Survey and Certification

Ensuring the safety and quality of care provided by health facilities is one of HCFA's most critical responsibilities. HCFA contracts with State agencies and other organizations to inspect health facilities providing services to Medicare and Medicaid beneficiaries to ensure compliance with Federal health, safety, and program standards. HCFA's quality oversight includes initial inspections of providers who request participation in the Medicare program, annual recertification, inspections of nursing homes and home health agencies (HHAs) as required by law, investigation of beneficiary complaints, and periodic recertification surveys of other health care providers and suppliers.

In FY 1998, the President's budget requests a total of $148 million for direct survey and certification activities and workloads. HCFA is also requesting legislation to allow States to charge initial fees to inspect new facilities requesting participation in the Medicare program. The Department's request and the legislation are necessary both to conduct initial inspections of more than 3,000 facilities expected to request Medicare participation, and to increase the frequency of annual surveys performed on non-long-term care facilities (e.g., ESRD facilities, hospices, rural health clinics). As mandated by OBRA 87, HCFA conducts recertification surveys (over 24,000) on nursing facilities and home health agencies annually. HCFA plans to reach a recertification coverage level on non-accredited hospitals and psychiatric hospitals, hospices and other providers of 10 percent.

As part of the Health Care Quality Improvement Program, HCFA is currently placing greater emphasis on effective internal quality management systems within Medicare facilities, as well as the provider's responsibility to monitor outcomes. In FY 1998, HCFA will be retraining surveyors across the country to reinforce our focus on patient outcomes, which will result in improved quality throughout the program.

Clinical Laboratory Improvement Amendments of 1988

The Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes. CLIA '88 also introduced user fees for clinical laboratories to finance survey and certification activities. User fees are accounted for in the Program Management account and are available until expended for CLIA activities. The CLIA program is fully operational with about 157,000 laboratories registered with HCFA; about 60 percent of the labs are subject to routine inspection under the program.

HEALTH CARE INITIATIVES

The President's health legislation package provides a number of added protections for children, working families, small businesses and States. The Administration proposes a "Healthy Working Families" program to help more than three million people (including 700,000 children) in unemployed families keep their health

insurance for up to six months. This proposal will cost $1.7 billion in FY 1998.

The Administration also proposes a "Healty Kids" initiative in order to reduce the number of uninsured children by half by the end of FY 2000. The budget provides $750 million in annual grants to States to build on recent State successes to develop innovative ways to provide coverage to children. The initiative also includes funds to allow States the option to extend one year of continuous Medicaid coverage to children.

The President's budget proposal also includes $25 million in grants to States for technical assistance to establish voluntary health insurance purchasing cooperatives to take advantage of economies of scale to which small firms normally do not have access in purchasing health insurance.

Finally, the budget package includes a proposal requiring States to assess a new user fee on health care providers for initial surveys required as a condition of participation in the Medicare program. The proposal assumes the collection of $10 million.

Healthy Working Families

- To assist families of temporarily unemployed workers, the Healthy Working Families program will provide financial assistance to unemployed workers and their families in maintaining health insurance. The new program would provide annual grants to participating States to finance up to six months of coverage for unemployed workers and their families. The program would be available to those who had employer-based coverage in their prior job, are now receiving unemployment benefits, and have an income below certain thresholds.

- An estimated 3.3 million Americans, including nearly 700,000 children, will benefit from this program. This proposal is estimated to cost $9.8 billion for FY1998-2002.

Expanding Health Coverage for Children

Nearly 10 million children --one in seven-- are uninsured in America today. Our goal is to significantly reduce this number through practical, incremental reforms. We believe this issue requires a multi-faceted strategy that involves a pragmatic series of incremental steps by both Federal and State governments as well as the private sector. These steps include:

Medicaid Initiatives

- Under current law, we will add an estimated 1 million children to Medicaid over the next four years under the scheduled phase-in of adolescents in families below the Federal poverty line.

- We will work with States to fulfill the promise of Medicaid for children who are already eligible under current law. An estimated 3 million children currently are entitled to Medicaid coverage but are not enrolled.

- As discussed in the Medicare section we have a legislative proposal to provide States with the option to allow continuous coverage to children, age 1 and older, for one year after eligibility is determined. This will guarantee more stable coverage for children and better continuity of health care services. This is estimated to cost $3.7 billion for FY 1998-2002.

Private Insurance Initiatives

- We will provide funding for States to support innovative partnerships to insure children not otherwise qualified to receive Medicaid or employer sponsored benefits. Building on the innovative steps that States have begun to take to insure children, we will provide $750 million in annual support to States to expand insurance coverage for children in their States. This proposal is estimated to cost $750 million per year, for a total of $3.75 billion for FY 1998-2002.

Voluntary Purchasing Cooperatives

- The President's plan would provide $25 million a year for five years to assist States in establishing voluntary purchasing cooperatives for small employers. By forming cooperatives, small employers can bargain collectively for lower rates, and at the same time, offer a greater array of health plan choices to workers than a single small employer can usually provide. The grants will provide initial start-up capital and technical assistance for cooperatives, both of which are often hard to obtain because cooperatives are typically non-profit.

PROGRAM MANAGEMENT OVERVIEW

(Obligations in millions)[1]

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Medicare Contractors	$1,201	$1,207	$1,223	+$16
Survey and Certification	148	158	148	- 10
Federal Administration	326	326	359	+ 33
Research	53	44	45	+ 1
Budget Authority (Current Law)	$1,728	$1,735	$1,775	+$40
Medicare Integrity Program	$396	$440	$500	+$60
Peer Review Organizations	548	79	82	+$3
CLIA	$29	$43	$43	$0
Program Level	$2,701	$2,254	$2,357	+$103
Outlays	$1,728	$1,734	$1,775	+$41
Legislative Proposals	$0	$0	$2,523	+$2,523
Healthy Working Families	0	0	1,738	+1,738
Grants for Health Insurance Co-op	0	0	25	+25
Healthy Kids State Partnership Grant	0	0	750	+750
Survey and Certification User Fee	0	0	10	+10
FTE	4,081	4,085	4,085	0

1 Numbers may not add due to rounding.

2 FY96 Actuals include fraud and abuse spending actually spent in the discretionary Medicare Contractor line under the Medicare Integrity Program for comparability purposes.

HCFA SUMMARY

(Outlays in millions)[1]

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Current Law:				
Medicare Benefits (includes PROs)	$191,264	$211,214	$229,903	$18,689
Medicaid Benefits (includes State admin costs)	$91,990	$98,503	$104,384	$5,881
HCFA Administration	$2,096	$1,839	$1,774	$-65
Other-HHS Administration	$894	$897	$1,015	$118
HCFAC	$0	$521	$596	$75
HMO Loan Fund	$-1	$-2	$-1	$1
Total Outlays, Current Law	$286,241	$312,972	$337,671	$24,699
Offsetting Receipts[2]	$-20,086	$-20,293	$-21,983	$-1,690
Total Net Outlays, Current Law	$266,155	$292,679	$315,688	$23,009
Proposed Law:				
Medicare	$0	$0	$-4,521	$-4,521
Medicaid	0	39	1,417	1,378
Program Management	0	0	2,523	2,523
Offsetting Receipts[2]	0	0	211	211
Total	$0	$39	$-370	$-409
CLIA (Non-Add)	(28)	(0)	(0)	(0)
Total Net Outlays, Proposed Law[3]	$266,155	$292,718	$315,318	$22,600
FTE	4081	4085	4085	0

1 Numbers may not add due to rounding.
2 Offsetting receipts include offsetting collections in program management and premiums collected from beneficiaries under Medicare HI and SMI.
3 Total net outlays equal current law outlays minus the impact of proposed legislation and offsetting receipts.

Administration for Children and Families

(dollars in millions)

Budget Authority:	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Discretionary	$7,215	*$7,785	$7,994	+$209
Entitlement	26,090	30,845	26,630	-4,215
Total	33,305	38,630	34,624	-4,006
Outlays:				
Discretionary	7,123	7,582	7,826	+244
Entitlement	23,900	27,442	28,695	+1,253
Total	31,023	35,024	36,521	+1,497
FTE	1,732	1,669	1,627	-42

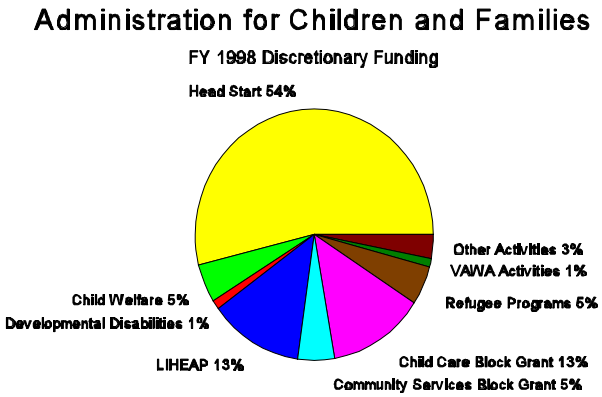
* Includes $937 million CCDBG funding available on October 1, 1998.

Summary

The Administration for Children and Families (ACF) is the Department's lead agency for programs serving America's children, youth and families. Its programs are at the heart of the Federal effort to strengthen families and give all children a decent chance to succeed. Head Start, child care, and child welfare services emphasize early childhood health and development. Through the Community Schools program and services for runaways, ACF promotes safe passages for our youth. In addition, ACF has responsibility for a range of social services and income assistance programs which support low-income families across the country.

For a number of years, ACF has been a principal player in working to overhaul the nation's welfare system which culminated in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act. ACF is responsible for the implementation and management at the Federal level of this new legislation including responsibility for administering the Temporary Assistance for Needy Families and the enhanced Child Support Enforcement programs. The reduction in budget authority for entitlements from FY 1997 to FY 1998 reflects the use of unexpended funds carried over from FY 1997 to FY 1998 for AFDC.

Discretionary Program Summary



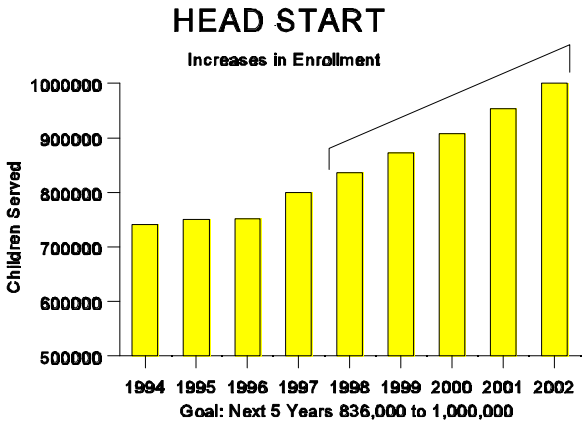
In FY 1998, ACF is seeking $8 billion for discretionary programs. Through a wide array of activities, ACF assists States and local communities in promoting opportunities for children and their families to grow, learn and thrive. By providing resources to States and community-based organizations, ACF helps to provide child development and care, meet the needs of the disabled, and support other special populations including refugees and Native Americans.

Head Start

One of the President's top priorities has been and continues to be investing in Head Start and expanding enrollment. In FY 1998, the President is seeking $4.3 billion for Head Start to serve an additional 36,000 children. This request, an increase of $324 million over FY 1997, will provide 836,000 children and their families with the comprehensive services that Head Start is famous for. This additional investment puts Head Start on track to serve 1 million children by the year 2002.

For over 30 years, Head Start has been this Nation's premier early childhood program, serving low-income children and families through comprehensive education, nutrition, health and social services. Evaluations of Head Start children continue to show that the Head Start experience has a positive impact on school readiness, increases children's cognitive skills, self-esteem, and achievement motivation, and improves school social behavior. Head Start also helps to improve the parenting skills and employment related skills of Head Start parents.

On November 5, 1996, Head Start published the most thorough revision of the Head Start Program Performance Standards in nearly 20 years. The standards are the key regulations that



set the guidelines and standards for quality in Head Start programs nationwide. In the spirit of the Administration's reinvention goals, the revised standards were developed based on communication and consultation with over 2,000 people and national organizations, including parents, national experts in child development, national children/family organizations, local community educators and Head Start staff. This new version reaffirms the core elements of the Head Start vision, as well as integrating new standards for infants and toddlers, reforming the structure of the standards for increased ease of use, incorporating emerging research knowledge and the expertise of health professionals, and highlighting the importance of collaboration between Head Start programs and the broader

community. Head Start is also continuing the process of developing Program Performance Measures to assess the quality and effectiveness of the program through outcomes and indicators. These measures are intended to provide a process for continuous improvement over time.

In previous years, only three to four percent of Head Start children were served in full-day full-year programs. Now welfare reform will be moving more parents into training or jobs, thereby increasing the need for full-day child care. To better meet the child care needs of these low-income families, Head Start is taking an innovative approach. Through collaboration and partnerships with local child care providers, Head Start programs will provide more high quality, full-day and full-year slots than ever before. The FY 1997 appropriation provided an additional $411 million, of which $227 million will be used to provide up to 50,000 additional children with full-day, full-year Head Start services.

In FY 1998, Head Start is continuing its commitment to infants, toddlers and pregnant women through increases in the Early Head Start program. The Early Head Start program was established in FY 1995 in recognition of the mounting evidence that the earliest years are extremely important to children's growth and development. Serving low-income children under the age of three, Early Head Start funds in FY 1998 will be equal to 5 percent of the total Head Start budget, or $215 million. These funds will support an estimated enrollment level of 35,000 children and their families. Children and families enrolled in Early Head Start will receive early, continuous, intensive and comprehensive child development and family support services.

Child Care & Development Block Grant

The FY 1998 proposed funding level for the Child Care and Development Block Grant (CCDBG) is $1 billion. This amount, combined with the $2.1 billion provided in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, will further the Administration's commitment to supporting working families and moving families from welfare to work.

Child care can be an enormous financial burden, particularly for low-income working families. The Child Care and Development Block Grant provides child care funds to States for low-income families with a parent who is working or attending a training or educational program.

The Administration's strategy is to help States build capacity to ensure adequate supplies of child care providers; expand programs to ensure that both working families and families on temporary assistance are served; link child care with other critical family services; leverage additional funds from the private sector and other sources; and evaluate results through data collection and research.

Community Services Block Grant

The Community Services Block Grant Program provides States, territories, and Indian Tribes with a flexible source of funding to help reduce poverty, including services to address employment, education, housing assistance, energy and health services. In FY1998, $415 million is requested for the Block Grant. ACF is not seeking funds for previously supported discretionary Community Services programs, i.e. Community Economic Development, Community Food and Nutrition, National Youth Sports and Rural Community Facilities.

Violence Against Women/Crime Bill Programs

Domestic violence is a serious problem in our society today affecting families all across the country. In FY 1998, ACF is requesting full funding for its Violence Against Women programs at $86.2 million, including $70 million for the Grants for Battered Women's Shelters program. This program, which includes Family Violence activities, helps States and Tribes provide immediate shelter and related services to victims of abuse and their dependents as well as domestic violence awareness activities. There are approximately 1,200 shelters in the United States. The Department of Health and Human Services helps to support approximately 1,000 of these.

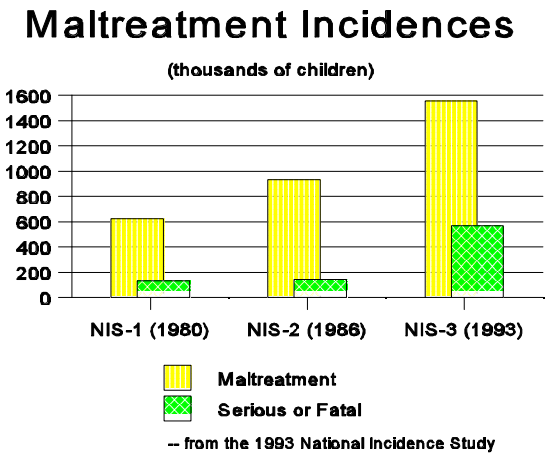
Another important component of the Department's Violence Against Women activities is the Domestic Violence Hotline (1-800-799-SAFE). HHS is requesting $1.2 million for this activity in FY 1998. This national, 24-hour, toll-free hotline provides crisis assistance, counseling, and local shelter referrals across the country. First begun in February, 1996, the hotline has received over 72,000 calls. Hotline counselors are available for English and non-English speakers and the hearing impaired.

The request also includes $15 million for Sex Abuse Prevention for Runaway and Homeless Youth and $12.8 million for the Community Schools program.

Child Welfare and Child Abuse

In FY 1998, the budget includes $389 million in discretionary funding for child abuse and child welfare programs, the same level as in FY 1997. This includes programs recently reauthorized in the Child Abuse Prevention and Treatment Act (CAPTA), and Title IV-B1 child welfare discretionary programs.

The findings of the recently released third National Incidence Study of Child Abuse and



Neglect (NIS-3) show a sharp increase in the scope of child abuse. An estimated 1.55 million children in the U.S. were abused or neglected. Of these reports, about half a million were reported serious or fatal. The total number of children abused or neglected was two-thirds higher in this study than in the last one conducted (in 1986).

Adoption Initiative

Today, there are over 450,000 children in America in our nation's foster care system. More than half have been in foster care for two years or longer. Over seven out of ten of these children are minorities or have other special needs -- they are disabled, older or have siblings who also need to be adopted. While the majority of these children return to their homes, nearly 100,000 do not. These children wait a long time, an average of three years, to be placed in permanent homes. Each year, State child welfare agencies secure homes for less than one-third of the children whose goal is adoption or another permanent placement. The

Administration seeks to improve this situation, and bring more waiting children into healthy, stable homes.

Last year, approximately 20,000 children were adopted out of the foster care system, and 7,000 were placed in legal guardianships. The Administration believes that by working with States to identify barriers to permanent placement, setting numerical targets, rewarding successful performance, and raising public awareness, States can double the number of adoptions and permanent placements to 54,000 children by the year 2002.

To accomplish this, the budget targets $21 million in discretionary spending to help States improve adoptions. Of this amount, $10 million will go towards training and technical assistance, $10 million towards identifying and removing barriers to adoption, and $1 million to public awareness. In addition, the Administration proposes paying incentives to States for increases in adoptions over the previous year under the Title IV-E Foster Care/Adoption Assistance program, to be offset by reductions in the cost of Foster Care payments.

Low-Income Home Energy Assistance Program (LIHEAP)

LIHEAP is a heating and cooling assistance program, targeted towards low-income households in the States, the U.S. Territories, Indian Tribes, and Tribal organizations. These funds support and protect the health and safety of nearly 6 million low-income households, including the elderly, disabled, and families with young children.

Flexible program requirements allow States the discretion to target assistance to the areas with greatest need. A portion of LIHEAP funds is set aside for weatherization, and to leverage additional energy dollars from non-Federal sources.

The FY 1998 level for LIHEAP is $1 billion. The request includes an additional $300 million contingency emergency fund. An advance appropriation of $1 billion in advance funding for FY 1999 is also included in the request.

Refugee Resettlement

The Office of Refugee Resettlement has been successful in resettling large numbers of refugees fleeing persecution in their home countries. Most recently, ORR has played a lead role in resettling over 6,700 Kurdish evacuees from Iraq. This has been done in partnership with private resettlement agencies, the States, and Federal agencies.

The FY 1998 budget request for the Refugee and Entrant Assistance program is $392.3 million plus $3.4 million in carryover funds, a $31 million decrease from FY 1997. The funding level is based on a projected refugee ceiling of 75,000 for FY 1998, the same level as in FY 1997. However, because refugees ceiling level are declining from the 110,000 which came into this country during FY 1996, the funding levels requested for FY 1998 can decrease slightly. In addition, the request will support the projected movement of 15,000 Cuban entrants under the U.S./Cuban joint migration agreeement. The funding level will provide Cash and Medical Assistance to refugees, as well as provide them with Targeted Assistance and Social Services through their States and a number of private resettlement agencies.

Developmental Disabilities

The FY 1998 funding for the Administration for Developmental Disabilities is $114.2 million, the same level as their FY 1997 funding. This program helps States to ensure that all persons with developmental disabilities are able to access

services for enhanced independence, productivity, integration, and inclusion in the community. The program provides grants to State Developmental Disability (DD) Councils, Protection and Advocacy Programs (P&As), as well as University-Affiliated Programs (UAPs) and Projects of National Significance.

Research

The FY 1998 request is $18 million for children's research and demonstration. While this does represent a $26 million reduction in direct spending, ACF has available $21 million in mandatory funds for FY 1998 to conduct welfare research and child welfare longitudinal studies. These fundsw were made available through PRWORA. This amount includes $6 million for a longitudinal child welfare study, and $15 million for welfare research.

Federal Administration

The FY 1998 level of funding for ACF Federal staff and operations expenses is $143.1 million, the same level as in FY 1997.

ACF Entitlement Program Summary

The Department's FY 1998 ACF Budget includes $28.7 billion in outlays for entitlement programs. Included within this total is funding for the Temporary Assistance for Needy Families program, the Contingency Fund for State Welfare programs, and the Child Care Entitlement to States. Funding for these programs was pre-appropriated by the Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193). The ACF entitlement budget also requests FY 1998 funding for Child Support Enforcement; Foster Care, Adoption Assistance, and Independent Living; Family Preservation and Support; and the Social Services Block Grant.

During FY 1998, ACF will complete transition to the new programs created by P.L. 104-193 and phase out the programs repealed by that Act, including Aid to Families with Dependent Children, AFDC Child Care, JOBS, and Emergency Assistance.

Temporary Assistance to Needy Families

Title I of P.L. 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), created the Temporary Assistance for Needy Families (TANF) program, which transforms welfare into a system that requires work in exchange for time-limited benefits. The legislation repeals the Aid to Families with Dependent Children (AFDC), AFDC Child Care, Emergency Assistance (EA) and the Job Opportunities and Basic Skills Training (JOBS) programs and replaces them with a single capped entitlement to States.

All States must implement TANF by July 1,1997; States have the option of implementing prior to that date. Until a State implements TANF, the State remains subject to the provisions of the AFDC, EA, and JOBS programs that were in effect as of September 30, 1996.

States have wide flexibility under TANF to determine their own eligibility criteria, benefit levels, as well as the type of services and benefits available to TANF recipients. Each family must be needy, as defined by the State, and must include (or be expecting) a child. States are required to assess the skills of recipients and help them prepare for and find work. Adult recipients must work after receiving assistance for 24 months or less, with few exceptions. States are also required to meet minimum participation rate requirements. Twenty-five percent of all families must be engaged in work

activities in FY 1997, rising to 50 percent in FY 2002. Seventy-five percent of two-parent families must participate in fiscal years 1997-98 and 90 percent thereafter. Families who have received assistance under TANF for five cumulative years (or less at State option) will no longer be eligible for assistance funded with Federal TANF dollars.

Programs Financed

The following activities are authorized and preappropriated under P.L. 104-193 for the implementation of the Temporary Assistance for Needy Families program and are integral parts of welfare reform:

- Family Assistance Grants to States and Territories;
- Matching Grants to Territories;
- Supplemental Grants for Population Increases;
- Tribal Work Programs;
- Loans for State Welfare Programs.

Contingency Fund for State Welfare Programs

Title I of PRWORA also established a Contingency Fund to assist those States which, due to economic hardship, need additional funds above their TANF grant to allow them to provide assistance to needy families. States are eligible for these matching funds during periods of high unemployment or rising Food Stamp caseloads. The total amount of Contingency Funds appropriated for FYs 1997-2001 is $2 billion.

Child Care Entitlement to States

The PRWORA authorized and pre-appropriated funds of $2.1 billion for child care programs to allow States maximum flexibility in developing child care programs. This amount, combined with the $1 billion requested for the Child Care and Development Block Grant, will further the Administration's commitment to supporting working families and moving families form welfare to work.

The programs financed by child care entitlements include the following:

- Mandatory Child Care - Mandatory funds are allocated to grantees based on historic levels of Title IV-A child care expenditures. Two percent of the total appropriation is set aside for Tribes.

- Matching Child Care - This is the total allocation, less the mandatory child care allocations and the two percent tribal set-aside. Matching funds will be distributed using the At-Risk Child Care Program formula and must be matchedat the FY 1995 Federal matching ratios (FMAP).

- Training and Technical Assistance - These amounts are set aside for training and technical assistance to States and Tribes.

Child Support Enforcement

The Child Support Enforcement (CSE) program is a joint Federal, State and local partnership that seeks to locate non-custodial parents, establish paternity when necessary, and establish and enforce orders for support. The Federal government shares in the financing of this program by providing a 66% match rate for

general State administrative costs, a 90% match rate for paternity testing, and 80% or 90% for specified automated systems requirements. The CSE program also includes a capped entitlement of $10 million for grants to states to support efforts to facilitate noncustodial parents' access and visitation of their children.

The CSE program strengthens families by helping children get the support they deserve from non-custodial parents. In non-TANF cases, child support collections are forwarded to the custodial family. By securing support on a consistent and continuing basis, non-welfare families may avoid the need for public assistance, thus reducing welfare spending. Applicants for TANF assign their rights to support payments to the State as a condition of receipt of assistance. TANF child support collections are shared between the State and Federal government. A portion of the Federal share of child support collections is paid to the States as incentive payments based on their cost effectiveness in operating the program and the collections achieved.

The PRWORA contains major revisions to the federal child support statute including: a State requirement to establish paternity as a condition of receiving TANF and Medicaid funds; State penalties for failure to enforce noncooperation of paternity establishment; new enforcement techniques, including the revocation of drivers and professional licenses for delinquent obligors; uniform rules, procedures, and forms for interstate cases; and the requirement that states establish centralized collections and disbursement units and State and National case registries and Directories of New Hires. Additionally, PRWORA requires that a report be submitted to Congress by March 1, 1997 which recommends a new incentive formula for the program.

In FY 1998, it is estimated that a total of $3.5 billion in Federal and State dollars will be expended in order to collect over $13.7 billion in payments. This represents an 8 percent gain in collections over FY 1997 and a total return of almost $4 for every dollar invested in the administration of the program. Since the inception of the program in FY 1975, a total of $95 billion has been collected.

Foster Care, Adoption Assistance and Independent Living

A total of $4.3 billion in budget authority is requested in FY 1998 for the Foster Care, Adoption Assistance and Independent Living programs. Of this request, $3.5 billion is requested for the Foster Care program, which will provide payments on behalf of almost 292,000 children each month. This request will also fund State administration, including child welfare case management systems, training, and State data systems. In FY 1998, under the Adoption Assistance program, ACF is requesting $701 million to provide subsidy payments to families who have adopted special needs children. Payments are made on behalf of adopted children up to their 18th birthday and this level of funding will support approximately 153,000 children each month. The Independent Living Program will receive $70 million to continue services to help teenagers under State supervision make the transition to living on their own.

Under the Adoption Initiative outlined earlier, the administration proposes paying incentives to States for increases in adoptions of children through the public system. This entitlement will result in no net increase in outlays because increases in Adoption Assistance will be offset by savings in Foster Care.

Family Preservation and Support

For FY 1998, $255 million is requested for States and eligible tribes as part of a continuing five-year funding plan started in FY 1994 to strengthen family preservation and support services. These services help State protection welfare agencies and eligible Indian tribes establish and operate integrated, preventive family, preservation services and community-based family support services for families at risk or in crisis. Family preservation services are activities that help families alleviate crises that might lead to out-of-home placements of children because of abuse or neglect. Family support services, often provided by community-based organizations, are voluntary, preventive activities to help families nurture their children. These activities help to prevent the unnecessary separation of children from their families and improve the quality of care and services.

Social Services Block Grant

The Social Services Block Grant is a grant to States, allowing them the flexibility to provide or supplement services at the State and local levels. Programs or services most frequently provided include child care and elder care, drug abuse prevention and treatment activities, home based services, employment services, foster care, adoption services, prevention and intervention programs, and special services for the disabled. The PRWORA reduced the authorization for the SSBG from $2.8 billion to $2.4 billion through FY 2002.

AFDC and Related Programs

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) replaced the Aid to Families with Dependent Children (AFDC) Benefits, State and Local Administration, Emergency Assistance (EA), IV-A Child Care, and Job Opportunities and Basic Skills Training (JOBS) programs with TANF and the Child Care Entitlement programs.

The AFDC program provided financial assistance to low-income families with dependent children who had been deprived of parental financial support due to the death, disability, unemployment or continued absence of a parent. States had the option of operating Emergency Assistance programs, which provided financial assistance and services to needy families with children to meet temporary, emergency needs. Funding for child care services were available under the AFDC/JOBS, Transitional and At-Risk Child Care programs. The JOBS program provided AFDC recipients with the education, training and employment services needed to avoid long-term welfare dependency.

FY 1997 estimates reflect the phaseout of funding for AFDC, EA and JOBS. States will receive funding for these programs for only part, if any, of FY 1997 due to their implementation of TANF. Estimates for FY 1998 represent claims for expenditures incurred before these programs were repealed. These claims will be paid from carry over balances from prior years.

CHILD SUPPORT ENFORCEMENT COLLECTIONS AND COSTS

(Dollars in millions)

	1996 Actual	1997 Enacted	1998 Estimate	Request +/- Enacted
Total Collections Distributed to:				
TANF/FC Families	$474	$149	$149	$0
Non-TANF Families	8,975	9,830	10,884	1,054
TANF Program	2,246	2,689	2,669	- 20
FC Program	24	26	27	+ 1
Total	$11,719	$12,694	$13,729	+ $1,035
Distributed to AFDC Program				
Net Federal Share	$857	$1,069	$1,032	- $ 37
State Share plus Incentives	1,389	1,620	1,637	+ 17
Total	$2,246	$2,689	$2,669	- $ 20
Administrative Costs				
Federal Share	$1,984	$2,335	$2,386	+ $ 51
State Share	982	1,060	1,150	+ 90
Costs	$2,966	$3,395	$3,536	+ $ 141
Program Saving and Costs (Collections minus Costs)				
Federal Costs	$1,127	$1,266	$1,354	+ $ 88
State Savings	(407)	(560)	(487)	+ 73
Net Costs	$720	$706	$867	+ $161

ACF OVERVIEW
ENTITLEMENT SPENDING

(Dollars in millions)[1]

	1996 Actual	1997 Enacted	1998 Estimate	Request +/- Enacted
Temporary Assistance for Needy Families[2]	$111	$13,658	$16,757	+ $3,098
Contingency Fund[2]	0	45	80	+ 35
Child Care Entitlement[2]	0	1,967	2,175	+ 208
Child Support Enforcement	2,390	2,782	2,833	+ 51
Foster Care/Adoption Assistance	4,322	4,445	4,311	- 134
Children's Research & Technical Assistance[2, 3]	37	32	66	+ 28
Family Preservation & Support	225	240	255	+ 15
Social Service Block Grant	2,381	2,500	2,380	- 120
AFDC/EA/JOBS/Related[4,5]	16,624	5,176	-2,226	- 7,397
Total, Program Level/BA	$26,090	$30,845	$26,630	- $4,215

1 Numbers may not add due to rounding.
2 Programs are preappropriated.
3 In FY 1996, $6 million and in FY 1997, $21 million of pre-appropriated funds in this account were rescinded by the Congress.
4 AFDC and related assistance is shown net of child support collections.
5 The negative budget authority shown for FY 1998 represents the use of funds carried over from FY 1997. Out of a total of $3,091 million available at the beginning of FY 1998, we estimate that $2,226 million will be expended.

ACF OVERVIEW
DISCRETIONARY SPENDING

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Head Start	$3,569	$3,981	$4,305	+$324
LIHEAP	1,080	1,005	1,000	-5
Child Welfare/Child Abuse	371	389	389	--
Adoption Initiative	0	0	21	+21
Refugee and Entrant Assistance	413	427	396	-31
Community Services Block Grant	389	489	415	-74
Comm. Services Discretionary Activities	46	47	--	-47
Runaway and Homeless Youth	59	59	59	--
Community Schools	--	13	13	--
Violence Against Women Activities	54	82	86	+4
Developmental Disabilities	114	114	114	--
Native Americans	35	35	35	--
Social Services Research	0	44	18	-26
Federal Administration	150	143	143	--
Child Care Block Grant*	935	19	1,000	NA
CCDBG Comparable**	--	937	--	NA
Subtotal, CCDBG	$935	$956	$1,000	+44
TOTAL, Program Level/BA	$7,215	$7,785	$7,994	+$210

*Of the $1 billion request for FY 1998, $937 million was advance appropriated in FY 1997.

**For the purposes of comparability, this line reflects the FY 1998 advance appropriation of $937 million as funds for FY 1997. Funds for this program over the past several years were not available for obligation until the last day of the fiscal year, effectively funding the program for the *next* fiscal year as opposed to the year in which the funds were appropriated. Moving the day in which funds can be obligated from the last day of the fiscal year to the first day of the next fiscal year merely formalizes this arrangement.

Administration on Aging

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Budget Authority 1/	$833	$836	$838	+$2
Program Level	833	836	838	+2
Outlays	820	855	835	-20
FTE	149	150	150	0

1/ Does not include $440 million for proposed transfer of Community Service Employment for Older Americans program from DOL to AoA in FY 1998.

Summary

The FY 1998 budget for the Administration on Aging (AoA) provides $838 million for programs aimed at improving older Americans' quality of life, primarily by helping senior citizens to remain independent and productive. The budget also reflects the Administration's desire to consolidate in AoA the management and oversight of programs that serve the elderly; towards that end, two transfers are proposed for FY 1998: the Health Resources and Services Administration (HRSA) will transfer the Alzheimer's Disease Demonstration Grants to States program to AoA, and the Department of Labor (DOL) will transfer administration of their Community Service Employment for Older Americans program to AoA.

AoA serves older persons and their families through the administration of the Older Americans Act and aging-related applied research and educational projects. As the focal point in the Federal Government for serving older persons, AoA works to advance the dignity and independence of the nations' elderly. By the year 2030, the number of people aged 60 and older will increase to 89 million, while those 85 and older will increase to almost nine million. AoA recognizes the need to address these demographic changes, and is striving to prepare both older and younger Americans for their aging.

Supportive Services and Centers

The FY 1998 budget request reflects AoA's commitment to ensure that older Americans have an independent, productive, healthy and secure life. Supportive services represent the cornerstone of the comprehensive and coordinated system of home and community-based services that address the needs of the elderly. The FY 1998 budget of

$291.4 million provides funding for a network of 57 State units on aging, 661 Area Agencies on Aging, 6,400 senior centers, and more than 27,000 service providers throughout the country. In FY 1995, supportive services and centers provided homemaker services to over 167,000 elderly, chore services to 66,000, case management services to 501,000, adult day care to 46,000, and personal care to 97,000. Of these clients, 39 percent were at or below the poverty level.

Nutrition Services

For FY 1998, AoA requests $469.9 million for nutrition services. Over 240 million meals were served in FY 1995 through the Aging Network; about half of meal recipients are low-income elders and about 16 percent of recipients are members of minority groups. Recipients of home-delivered meals are among the most vulnerable elderly in the community, with 73 percent considered to be frail and disabled and 53 percent being low-income. Between 1980 and 1995, the number of home-delivered meals increased by 227 percent, reflecting not only a growing elderly population but also an elderly population composed of increasingly older and more frail individuals. Moreover, the volunteers who deliver the meals often serve as informal gatekeepers, assessing whether recipients have other needs and linking them to additional services.

Congregate nutrition services provide a cooked, nutritious meal to seniors in a group setting. Participation in a group setting reduces isolation and encourages continued physical and mental functioning. The Older Americans Act directs that priority be given to those who are in greatest economic and social need, with particular attention to low-income, minority older persons.

Grants to States for Protection of Vulnerable Older Americans

The FY 1998 budget proposes a consolidation of the various programs authorized under Title VII of the Older Americans Act into a single grants program, with total funding of $9.2 million. Title VII programs include: long-term care ombudsman services; prevention of elder abuse, neglect and exploitation; State elder rights and legal assistance development; and outreach, counseling and assistance.

While each of these programs has its own distinct mission within the overall Title VII mission of protecting vulnerable elder rights, all four work in conjunction with each other at the State level, forming a synergy which increases the effectiveness of each. Therefore, the FY 1998 budget proposes to consolidate funding for these activities into a single line item. Funding these complementary activities together will ensure that States have the flexibility to meet the most pressing needs of their vulnerable elderly populations.

Other AoA Programs

The FY 1998 budget request also provides $9.3 million for in-home services for the frail elderly (Title III-D). The rapid growth of the age 85 and over population brings new demands for care because of limited mobility, increasing disability, more elderly living alone and the higher risk of poverty. By supporting the provision of services to frail older individuals, the program increases the access of vulnerable older individuals to needed assistance and helps them avoid institutionalization.

Other activities funded through AoA include: $16.1 million for grants to Native Americans (Title VI); $15.6 million for preventive health services (Title III-F); and $4.0 million for aging training, research and

related programs (Title IV) to enhance the capacity of State, local and tribal governments and non-profit entities to develop and improve the quality and effectiveness of services for older individuals.

Alzheimer's Initiative

The number of people in the U.S. with Alzheimer's disease or related disorders is expected to double in the next 20 years, from the current level of nearly four million. In response to the growing pressures for assistance for these Alzheimer's patients and their caregivers, the administrative responsibility for the Alzheimer's Disease Demonstration Grants to States (ADDGS) program is proposed to be transferred to AoA from HRSA. AoA will continue to build upon the expertise gained from ADDGS so far, and will strive to continue the creation of innovative approaches for linking these patients and caregivers with health care providers, including physicians, community organizations, and private industry.

The requested funding level of $8.0 million will allow on-going experimentation with and refinement of innovative program models; these models can then be implemented in States and communities to more effectively serve the rapidly growing number of Alzheimer's patients and their caregivers.

Older Workers Program

Finally, the Administration's bill for reauthorizing the Older Americans Act includes a proposal to transfer DOL's Community Service Employment for Older Americans program (Title V) to AoA. Such a transfer would ensure national responsiveness to local community needs by allowing State and local agencies increased flexibility to consolidate, coordinate, link and expand limited resources to enhance community service, employment and training for low-income seniors. The proposed transfer totals $440.2 million in FY 1998.

AOA OVERVIEW

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Supportive Services and Centers	$291	$291	$291	$0
Nutrition Services:				
Congregate Meals	365	365	360	-5
Home-Delivered Meals	105	105	110	+5
Subtotal, Meals	470	470	470	0
In-Home Services--Frail Elderly	9	9	9	0
Grants to Indian Tribes	16	16	16	0
Preventive Health Services	16	16	16	0
Research, Training and Demonstration	3	4	4	0
Grants to States for Protection of Vulnerable Older Americans	9	9	9	0
Alzheimer's Initiative 1/	4	6	8	+2
Federal Administration	15	15	15	0
Total, BA/Program Level	$833	$836	$838	+$2
Proposed Transfer: 2/				
Department of Labor--Older Workers Program	*$373*	*$463*	*$440*	*-$23*
FTE	149	150	150	0

1/ Comparable transfer from HRSA for FY 1996 and FY 1997.

2/ Proposed bill language transfers $440 million for administration of DOL's Community Service Employment for Older Americans program to AoA. FY 1996 and FY 1997 levels for this program are provided for comparison purposes only; the FY 1997 increase was to finance the cost of the minimum wage increase.

General Departmental Management

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/-Enacted
Budget Authority	$168	$199	$174	-$25
Program Level	188	219	194	-25
Outlays	140	212	182	-30
FTE	1,220	1,217	1,217	0

Summary

The FY 1998 budget request provides a program level of $194 million for General Departmental Management (GDM), including an appropriation of $174 million and intra-agency transfers of $20 million in one-percent evaluation funds. GDM supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department through nine Staff Divisions (STAFFDIVs): the Immediate Office of the Secretary, the Offices of Public Affairs, Legislation, Planning and Evaluation, Management and Budget, Intergovernmental Affairs, General Counsel, and Public Health and Science, and the Departmental Appeals Board. In FY 1998, Policy Research -- formerly a separate appropriation account -- is included in the GDM request.

Office of Public Health and Science

In addition to serving as senior advisor on public health and science issues to the Secretary, the Assistant Secretary for Health also exercises management responsibilities for the following OPHS operational programs:

- **Office of Population Affairs** -- The request of $14 million provides support for the Adolescent Family Life (AFL) Demonstration and Research program authorized under Title XX of the Public Health Service Act. Through these grants, AFL provides funding for three areas: care demonstration projects, prevention projects, and research projects. In addition, OPA administers the Family Planning program under Title X of the Public Health Service Act (this program is funded though the Health Resources and Services Administration).

- **Office of Minority Health** -- The request includes $23 million to improve disease prevention, health promotion, and health service delivery for disadvantaged and

minority individuals and supports research on minority health topics, the goal of which is to improve the health status of racial and ethnic minority populations in the United States which continues to lag behind the health status of the American population as a whole. This request is a $11.5-million reduction from FY 1997, when the Congress included one-time funding for extramural construction projects.

- **Office on Women's Health** -- The request of $13 million provides funding for women's health programs by coordinating and stimulating research, service delivery, and education programs across the agencies and offices of HHS, with other government organizations, and consumer and health professional groups to advance women's health.

- **Office of Emergency Preparedness** -- The budget request of $10 million would be used to manage and coordinate the health and medical and health-related social services that are provided by the Federal Government to victims of catastrophic disasters through the Federal Response Plan Emergency Support Function (ESF) #8. Under ESF #8, HHS coordinates the support of the 12 Federal agencies in the preparedness for, response to, and recovery from natural and man-made disasters.

  Specifically in FY 1998, this request will permit OEP to carry out tasks from the National Security Council to assess and remedy any shortfalls in the health and medical consequence response capabilities necessary in the event of a terrorist use of a weapon of mass destruction, be it chemical, biological or nuclear.

- **Office of Disease Prevention and Health Promotion** -- The request of $4 million supports the coordination of crosscutting health promotion and disease prevention activities, including Healthy People 2000, the program for health goals for the nation, public health issues related to managed care, consumer health information, and efforts to strengthen the public health infrastructure among the Department's Operating Divisions, with other Federal Departments, and with the private and voluntary sectors.

Policy Research

The FY 1998 budget request includes $9 million for Policy Research (PR) to support research on policy issues of national significance. This is a $9.5-million reduction from FY 1997, when the Congress included one-time funding for a GAO study of the effects of medical savings accounts. Priority issues that will be examined are those related to welfare reform, health care, insurance reform, family support and independence, poverty, at-risk children and youth, aging and disability, science policy, and improved access to health care and support services.

GDM OVERVIEW

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/-Enacted
GDM Staff Divisions	$105	$101	$102	+$1
OPHS Program Offices:				
Minority Health	$28	35	23	-12
Adolescent Family Life	8	14	14	--
Women's Health	7	12	13	+1
Emergency Preparedness/Anti-Terrorism	8	14	10	-4
Council on Physical Fitness & Sports	1	1	1	--
Subtotal, OPHS program Offices	52	76	61	-15
Policy Research	9	19	9	-10
U.S. Office of Consumer Affairs	2	2	2	--
TOTAL, GDM	$168	$198	$174	-$24

Office for Civil Rights

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Budget Authority	$20	$20	$21	+$1
Program Level	20	20	21	+1
Outlays	18	20	20	0
FTE	242	242	242	0

Summary

The FY 1998 budget request for the Office for Civil Rights (OCR) is $21 million, an increase of $1 million over the FY 1996 and FY 1997 levels. OCR is responsible for enforcing civil rights statutes that prohibit discrimination in Federally-assisted health care and social services programs. These statutes cover nondiscrimination on the basis of race, national origin, disability, age, and in limited instances, sex and religion.

In addition, OCR is responsible for coordinating the implementation of the Section 504 regulation that prohibits discrimination against persons with disabilities in programs and activities conducted by HHS. OCR enforces nondiscrimination requirements by processing and resolving discrimination complaints, conducting reviews and investigations, monitoring corrective action plans, and carrying out voluntary compliance, outreach and technical assistance activities.

OCR has made significant progress in addressing issues such as race discrimination in access to health care and discrimination against persons with disabilities. In FY 1996, OCR completed 5,279 discrimination complaint and review cases, with 40 to 50 percent of the cases resulting in changes in policies and practices.

This budget request reflects the continuation of the implementation of OCR's strategic plan. The plan has resulted in significant re-engineering of OCR's investigative and compliance processes through redesign and streamlining. The plan calls for expanded use of innovative partnerships both within HHS and at the State and local levels to ensure civil rights compliance. As a result of strategic plan initiatives, review and complaint investigation production is projected to increase by more than 20 percent.

In addition, the FY 1998 budget request includes funds to support outreach and other compliance initiatives that seek new ways of preventing civil rights problems and addressing potential discrimination in HHS programs. This includes implementation of new nondiscrimination requirements covering adoption and foster care placements that will support the President’s Adoption 2002 initiative to double adoption placements.

OCR OVERVIEW

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Total, BA	$20	$20	$21	+$1
FTE	242	242	242	0

Office of Inspector General

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Budget Authority	$37	$35	$32	-$3
Program Level [1/]	81	105	112	+7
Outlays	72	109	113	+4
FTE	943	1,014	1,053	+39

1/ The FY 1998 Program Level for OIG includes an estimate of mandatory funding based on a pro-rata distribution of the FY 1997 allocation in the Health Care Fraud and Abuse Control (HCFAC) Program. Actual FY 1998 funding decisions for the HCFAC Program are pending agreement and certification by the Secretary of HHS and the Attorney General.

Summary

For FY 1998, the Office of Inspector General (OIG) requests a discretionary appropriation of $32 million, a decrease of $3 million below the FY 1997 discretionary level. The OIG will also receive between $80 and $90 million in FY 1998 from the Health Care Fraud and Abuse Control (HCFAC) Account for Medicare related fraud and abuse activities.

The OIG is charged with conducting and supervising audits and investigations relating to programs and operations of HHS; providing leadership and coordination for, and recommending policies and corrective actions concerning, activities designed to promote economy and efficiency in the administration of the Department's programs; and preventing and detecting fraud and abuse in HHS' programs and operations.

The OIG plans to intensify its efforts, and in FY 1998, the Office will focus a substantial amount of its resources in the following program areas:

- Increasing Collections in the Child Support Enforcement Program. These reviews will evaluate various options and methods -- such as the effective use of judicial or administrative processes to revoke various types of State licenses belonging to delinquent non-custodial parents and wage withholding.

- FDA Processes. The OIG will assess the adequacy of the Food and Drug Administration's controls over investigational new drugs, review FDA regulation of Institutional Review Boards, and evaluate FDA Device Safety Alerts.

- Public Health Fraud. Investigations of fraud in public health programs are diverse, complex, and often critical to protecting the health of the American people. These investigations will address grant and contract fraud, research fraud, and allegations of wrongdoing.

- Medicare and Medicaid. The OIG expects to complete work already underway on home health, hospices, nursing home services and several items of durable medical equipment. The office will also continue work involving prescription drug payments in both the Medicare and Medicaid programs. Additional savings and recoveries are expected to come out of that work. Further, the OIG intends to continue similar cooperative activities on these and related subjects at a national level. The OIG will continue its monitoring of physician and hospital reimbursement issues. For example, the office will determine whether a targeted approach for identifying hospital miscoding is effective; the effect of hospital ownership of physician practices on billing practices and utilization; and whether hospitals are correctly coding patient stays. The OIG also plans to assess the physician's role in controlling non-physician services and supplies and will continue reviewing Medicare compliance by physicians at teaching hospitals.

In recent years, the OIG has forged new and stronger links with others in the Federal and State Government, and the private sector who are working toward similar goals. These multi-disciplinary approaches have greatly enhanced the office's ability to carry out its mission. Among these initiatives was the establishment of the Executive Level Health Care Fraud Policy Group, through which the OIG and the Department of Justice have jointly managed the development of investigative cases.

Other cooperative efforts include State and Federal audit partnerships to monitor the Medicaid program and Operation Restore Trust, an ambitious interdisciplinary project in which Federal and State agencies joined to fight fraud, waste and abuse in home health agencies, nursing homes, and the medical equipment and supply industry. The 2-year demonstration project, which ends in March of this year, targeted five States which account for about 40 percent of the Nation's Medicare and Medicaid beneficiaries. The OIG has found cooperative intergovernmental and industry approaches so successful in the past, it will continue to apply these methods to future projects.

OIG OVERVIEW

(dollars in millions)

	1996 Actual	1997 Enacted	1998 Request	Request +/- Enacted
Discretionary Appropriation	$37	$35	$32	-$3
Mandatory (HCFAC Account) [1/]	44	70	80	+10
Total, Funding Resources	$81	$105	$112	+7
FTE	943	1,014	1,053	+39

1/ The FY 1998 estimate of mandatory funding for the OIG is based on a pro-rata distribution of the FY 1997 allocation in the Health Care Fraud and Abuse Control (HCFAC) Program. Actual FY 1998 funding decisions for the HCFAC Program are pending agreement and certification by the Secretary of HHS and the Attorney General.

Program Support Center

(dollars in millions)

	1996 Actual	1997 Estimate	1998 Estimate	Increase +/- Decrease
Expenses	$233	$235	$235	0
FTE	1,149	1,100	1,100	0

Summary

The Program Support Center (PSC) became operational in FY 1996 and was formed by combining administrative activities formerly located in the Office of the Secretary, and funded by the OS Working Capital Fund (WCF), with activities from the former Office of the Assistant Secretary for Health (OASH), and funded by the PHS Service and Supply Fund. The formation of the PSC resulted from the Department's REGO II analysis with a goal of further streamlining and minimizing duplication of functions in the provision of cost effective administrative services to components of the Department and other Federal agencies. Services are provided in four broad areas: human resources, financial management, administrative operations, and information technology.

Human Resources Service

The FY 1998 estimated expenses for the Human Resources Service (HRS) are $39 million, a reduction of $7 million below the FY 1997 level. HRS provides a full range of personnel management services including payroll management and operations; personnel operations services for civilian and commissioned personnel; common needs training; employee relations and labor relations; and administration of the Board for Corrections of PHS Commissioned Corps Personnel Records.

Financial Management Service

The Financial Management Service (FMS) estimates its expenses at $40 million for FY 1998. FMS supports the financial operations of HHS and other Departments through the provision of payment management services for Departmental and other Federal grant and program activities; accounting and fiscal services; debt management services; and the review, negotiation and approval of rates, including indirect cost rates, research patient care rates, and fringe benefit rates.

Administrative Operations Service

The Administrative Operations Service (AOS) supports the administrative management functions within the Department in the areas of

property and materiel management, and support services ranging from telecommunications services and commercial graphics to mail distribution. Included is the operation of a medical Supply Service Center located in Perry Point, Maryland, that provides support to over 1,700 customers on a worldwide basis and is an economical source of supply for all Federal customers. The FY 1998 estimated expenses of $146 million for AOS includes a $6 million increase for the expansion of product lines within the Supply Service Center.

Information Technology Service

The FY 1998 estimated expenses for the Information Technology Service (ITS) are $10 million. The ITS provides automated data processing services for HHS and other Federal entities. The ITS provides customers with various IT services, resources, technical support and ADP planning assistance. In addition, the ITS develops and operates the Departmental Information Management Exchange System, a nationwide data communications network; and serves as the HHS Executive Agent for Department-wide connectivity.

Program Support Center

Entitlement Spending

Retirement Pay and Medical Benefits for Commissioned Officers
(dollars in millions)

	1996 Actual	1997 Estimate	1998 Estimate	Increase +/-Decrease
Retirement Payments	$119	$139	$149	+$10
Survivor's Benefits	9	11	12	+1
Medical Care	24	26	28	+2
Military Service Credits	3	3	2	-1
Total, BA	$155	$179	$191	+12
Outlays	$170	$180	$190	+10

Summary

This appropriation provides for retirement payments to Public Health Service (PHS) Commissioned Officers and payment to survivors of deceased retired officers. This account also funds the provision of medical care to active duty and retired members and to dependents of active duty, retired and deceased members of the PHS Commissioned Corps. In addition, this account includes amounts to be paid to the Social Security Administration for military service credits which are earned by active duty Commissioned Officers for non-wage income.